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# 'Food & Healing' Conference

## Tuesday 21st January 2003

Queen Elizabeth II Conference Centre
Westminster, London

DH Department of Health

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### Contents



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# Follow-up Networks

Better Hospital Food Panel chair Loyd Grossman suggested that Trusts having developed interests in specific areas as a consequence of attending the Food & Healing conference – or where hospitals are already well advanced with aspects of food / nutrition programmes – might wish to network in order to share and develop best practice. The intention is to hold a feedback conference in the autumn to report on activity and outcomes in relation to these networks.

I am interested in joining the following Key Theme Networks:

- **Beating expectations** ☐
  Improving the 'whole' meal experience for patients with a special focus on the environment. If we get just a few key environmental drivers right, does this mean satisfaction is enhanced? Or are there a wide range of things we need to work on, and what is the relative importance of each?
- **A quality service** ☐
  Most food service providers have SLAs or formal contract agreements with the ward/hospital or Trust. What are the best ways of specifying service needs and monitoring standards? Who should do this, and what best practice methods can be deployed to build the provider/user relationship? How can we further empower Matrons to set standards and make judgements about quality, especially in relation to food and nutrition services?
- **Personalising the service** ☐
  Providing patients with new highly personalised services that feature flexible use, ease of access and individually-tailored attributes is key to making them feel special and cared-for. How far can we extend personalised services across the patient experience as a whole? How can housekeepers help deliver these new services, and to what extent can they be extended throughout the hospital (not simply at ward level)?
- **Sustainable development** ☐
  What are the options and benefits arising from 'Claiming the Health Dividend' in terms of food and food services. How can we best support local purchasing, local employment and community involvement in terms of the food and meals chain?
- **Nutritional screening** ☐
  To what extent are there a few simple guiding principles involved in nutritional screening for patients on admission in order to identify those at risk? How should patients continue be reviewed to prevent them becoming at risk during their stay in hospital – and by whom?
- **Clinical governance** ☐
  To what extent can we promote food and nutrition as part of the clinical governance agenda for hospitals and Trusts? Who are the key stakeholders in this process, and what are the drivers that form the justification for the inclusion of food in risk management programmes?
- **Making the link** ☐
  To what extent can the practical application of food and nutrition as a fundamental aspect of clinical care obviate the need for some clinical interventions? In this context, can care costs be reduced, wound healing improved and other positive benefits accrued from the use of appropriate diet and nutritional support at critical points in the patient journey?

**Name:** .....

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**Loyd Grossman**
**Chair, Better Hospital Food panel**
**CHAIRMAN'S WELCOME AND OPENING REMARKS**

Loyd opened the conference and remarked how delighted he was to see around 400 senior people from the NHS coming together to share best practice around food and nutrition. He explained that the day had been designed around solutions based on evidence and best practice from the UK, together with contributions from the USA and Scandinavia, relating to the changing expectations and needs of patients in terms of hospital food and nutrition services. The conference would also make explicit the crucial link between food and nutrition, especially where this link gives rise to improved clinical outcomes for patients, together with economic and operational benefits for the NHS.

Loyd said that since the Secretary of State for Health, Alan Milburn, had asked him to chair the Better Hospital Food Panel in 2001, he had found Ministers giving a solid and unwavering commitment in terms of both the modernising agenda and providing patients with high quality basic care services. He commended the 'tremendous enthusiasm' of Lord Hunt, the Health Minister, in supporting the Better Hospital Food and PEAT programmes: 'This is a real asset. I look forward to making more use of this high level support.'

Loyd said: 'We can't fix things on this scale overnight, but the last two years have seen a significant improvement in quality and the range of services offered. We are moving with purpose, determination and focus, and we will achieve the long-term aim of improving the range and quality of food and nutrition services to patients over the next couple of years.'

**Lord Philip Hunt**
**Parliamentary Under-Secretary of State (Lords) for Health**

Lord Hunt paid tribute to the work done by Loyd Grossman in leading the BHF programme.

Lord Hunt acknowledged that food and nutrition are a crucial component of the patient's overall experience, and provided important benefits in terms of well-being and clinical outcomes. He welcomed the proportion of delegates from the Boards of NHS Trusts and PCTs, inviting them to 'sign up' to improving food service programmes at their hospitals: 'I can assure you that time spent in doing so will be very well rewarded in terms of the way your organisation is judged in the future. We cannot underestimate the importance of getting our basic care services right – patients expect this and it means a great deal to them.'

Lord Hunt reviewed the last two years, saying that many BHF-related challenges which had seemed insurmountable had proved possible: over 100,000 patients each day now have access to meals around the clock, receive additional snacks, choose new dishes designed specifically for the NHS, or take their main meal in the evening. 'Some Trusts haven't found it easy. But the provision of modern services reflecting changes in lifestyle cannot be seen as an optional extra.' He said that the BHF programme was 'not in reality an issue about money – it is more an issue about changing the mindset so that service providers listen carefully to what patients say, designing services and service standards to meet these changing needs.'

He went on to highlight the importance of raising food service standards at ward level, alongside the improvements in food. 'This seems to be a challenge for any number of Trusts, and it is something we must confront.' He paid tribute to the work done by ward housekeepers.

'None of this happens in isolation. I'm well aware that unless you get commitment at a Board level, it's very difficult for hotel service managers, modern matrons and other staff involved in food and food service to drive through these changes,' Lord Hunt said. 'I hope that those of you who are here today will ensure that in future these issues are discussed frequently at Board level.' He remarked that CHI and PEAT will continue to look at food services as part of the patient environment, and the first PEAT outcomes will be published on a hospital by hospital basis in February, 'which will in itself indicate to Trust boards that this is a matter for close attention.'

Lord Hunt encouraged delegates to look at the wider aspects of improving the whole meal


**"We are moving with purpose, determination and focus, and we will achieve the long-term aim of improving the range and quality of food and nutrition services to patients over the next couple of years."**

*– Loyd Grossman*
*Chair, Better Hospital Food Panel*

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**"We cannot underestimate the importance of getting our basic care services right – patients expect this and it means a great deal to them."**

*– Lord Hunt*
*Health Minister (Lords)*

**"There is a correlation between how good you think food will be, and how highly you rate it. You have to address people's expectations of your product, because this determines how they will like it."**

*– Dr Herbert Meiselman*
*US Army*

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experience, mentioning "Protected" mealtimes, the ability for able patients to eat away from their bed, flexibility in eating times and off-ward dining with visitors as potential avenues for exploration. 'It's about creating opportunities for a more personalised service.'

Lord Hunt touched on the NHS's procurement system: 'We want to work with the NHS to make sure the procurement system provides adequately for the significant changes taking place in the way food service operations are organised at hospital level.' The NHS must set a good example of corporate citizenship, and also work hard to develop and support the sustainability agenda. He noted the work done at the Royal Cornwall Hospital NHS Trust concerning food procurement, production facilities and local employment opportunities. He had recently met with the Parliamentary Under-Secretary for Farming, Food and Sustainable Energy, Lord Whitty, to discuss how best to support schemes based on the sustainability agenda. He said in future the private sector would be consulted for advice, help and partnership in relation to the development of food systems so that the NHS was able to take advantage of modern techniques and practices.

Lord Hunt's final remarks concerned training and development for food production and service staff. 'We want to ensure that catering staff and managers perceive the NHS as a good place to work and develop skills, with an exciting career structure. Those representing Trusts here today have an important role in encouraging and supporting staff to take forward these changes.' Lord Hunt said that at a national level he would be keen to see an NHS Chefs' Training Programme.

**Dr Herbert Meiselman**
**Senior Research Scientist, US Army Natick Soldier Centre**

Dr Meiselman told the conference that he had spent many years in the USA and around the world researching the impact that context and environment can have on the perceptions of people eating food. He had extensive experience of working with soldiers in the US Army. He also made the point that his work in institutional food service has been extensive, and said he would endeavour to provide an overview in the time available.

He began by showing a slide that demonstrated how people expected food quality to vary in different eating environments: hospitals came out at the bottom of the list.

But the criticism was not equal across all groups of people, although it is easy to assume that different groups would see the same food in similar ways. Amongst staff, food service workers were more critical, and younger staff particularly so; amongst patients, younger patients were more critical, and dining-room eaters were more critical than those on the ward.

Dr Meiselman observed that the issue of waste in hospitals differed depending on what was being measured and the technique deployed. Two different standards have been set for hospital food waste – in the UK (20% of plated waste and unserved bulk trolley waste) and Australia (20% of plated waste, and 5% of unserved bulk trolley waste). However, according to a study carried out in the UK by Edwards and Hartwell in 2003, actual waste figures for plated waste can be as high as 51% in the UK, with 38% waste for trolley waste. 'These are very high levels of waste,' said Dr Meiselman.

Some of the reasons for high waste have been set out in a number of different studies. These include large portions of food, stress from medical treatment, food preparation, patient's food preferences, food/tray appearance and food temperature (Hirsch et al, 1979); inability to serve oneself, meal scheduling, unpleasant environment and poor health/appetite (Deutskom et al, 1991); and unpalatable food and receiving the wrong food (Stephen et al, 1997).

Dr Meiselman provided some history on the approach to issues around the consumption of food. Initially, food itself was the target for improvement; then, in the second half of the twentieth century the eater became a focus of attention, with emphasis on psychology, physiology, nutrition etc); and finally, in the last 15 years, the environment in which people eat has also begun to receive attention.

Dr Meiselman described a study evaluating a series of food products with a group of soldiers

over 34 days. On a daily basis the soldiers were asked to rate how good the food was. They were also weighed, and the amount they ate was measured in detail. The acceptance rating (7 on a 9-point scale) remained high, but the soldiers did not eat as much as expected – 1600kcals per day as opposed to the average expected consumption of 3600-3900 – and averaged a loss of 5% of body weight.

Surprised by these results, Dr Meiselman and his colleagues took identical food products to a university and tested them on students for 44 days. The students ate 1000 more calories per day than the soldiers, but gave the food a lower rating.

A further study was undertaken. In an army installation, the same food products were served to soldiers in the field and in the dining room, which generated an identical effect to the previous studies: a 1000kcal difference between those eating indoors and those eating outdoors.

Dr Meiselman and his colleagues realised that underconsumption of food in the army tests was due to a variety of reasons concerning the food and the individuals eating it. Food-related reasons were monotony (diet, texture, etc), quality and inadequate beverage supply. Individual-related reasons included stress, disturbed sleep pattern, heavy energy expenditure, novel food neophobia, variety-seeking behaviour with monotonous ration, and restrained eating in the field.

However, for the first time, the research team was led to also consider the eating environment as a factor in underconsumption. A variety of factors were all thought to contribute to underconsumption, including no fixed mealtimes, restricted socialisation, no chairs and tables, the effort needed to obtain food, the restricted ability to heat and cool food and the ambient temperature. Dr Meiselman went on to speak about the four main factors affecting consumption. These are the presence of other people; choice and variety; meal context; and different contexts/different people.

The presence of other people is fundamental, said Dr Meiselman: it affects how long we eat, how much we eat and what we eat. Eating alone out of choice, he said, was an interesting field of study, especially in view of the sociological focus on social interactions at meals. The practical question is whether isolation in the hospital setting depresses intake as it does in normal life.

The first published study on what Dr Meiselman called 'the social facilitation of eating' was published by the University of Georgia in 1987: a group of people were given pocket diaries to note everything they ate or drank, the time, the amount, how the food was prepared, how hungry they were and the number of people present, for a total of seven days. The study found that meals eaten when alone are fewer in frequency and less in calories (*Figure 1*).

**"INFLUENCE OF THE PRESENCE OF OTHER PEOPLE"**

**Social Facilitation**

**DeCastro & DeCastro, 1987, Amer. J. Clin. Nutrition**

Paid subjects

Pocket diary – record every item eaten or drunk, time, amount, preparation, hunger, and number of people present.

1 day training – 7 day data collection

| Meals eaten alone | Meals eaten with others |
|---|---|
| Energy – 410 Kcal | 591 – Kcal |
| CHO – 190 | 241 |
| fat – 157 | 230 |
| protein – 65 | 100 |
| 1.61 meals/day | 2.12 meals/day with 2.83 other people |

*Figure 1*

The presence or absence of other people has a powerful effect, shown to hold in all kinds of eating environments. More is eaten at dinnertime than at lunchtime than at breakfast, and the number of people present tends to be greater at dinner than at lunch than at breakfast: a good correlation. People eat more in restaurants than at home; more at meals than at snacktimes; and more with alcohol than without alcohol, where again more people tend to be present.

Dr Meiselman remarked that 'this is one of the most powerful effects we have working for us in the cause of improving consumption and nutrition. When you eat with other people, you spend longer at the table, and if you spend longer at the table, you eat more.'

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| Refectory | Hedonic Scale | n |
|---|---|---|
| Beef and Green Pepper Stew | 6.25 | 20 |
| Beef Casserole | 6.42 | 12 |
| Diced Potatoes | 5.45 | 20 |
| Par Boiled Rice | 5.92 | 12 |
| Chocolate Mousse | 4.73 | 15 |
| Apple & Cinnamon | 5.93 | 14 |
| Overall | 6.16 | 32 |

| Grill Room | Hedonic Scale | n |
|---|---|---|
| Beef and Green Pepper Stew | 6.50 | 10 |
| Beef Casserole | 6.63 | 8 |
| Diced Potatoes | 5.10 | 10 |
| Par Boiled Rice | 7.43 | 7 |
| Chocolate Mousse | 6.50 | 12 |
| Apple & Cinnamon | 6.22 | 9 |
| Overall | 7.06 | 18 |

*Figure 2*

**MEAN FOOD ACCEPTANCE RATINGS FROM THREE SETTINGS**

**Laboratory/Dining Halls/Training Restaurant**

**Fettuccine Alfredo with Chicken**

| | | Flavor | | Texture | | Color | | Overall | |
|---|---|---|---|---|---|---|---|---|---|
| | | mean | sd | mean | sd | mean | sd | mean | sd |
| Lab. | N 89 | 5.80 | 1.23 | 5.15 | 1.33 | 5.65 | 1.17 | 5.79 | 1.03 |
| D.H. | 113 | 5.18 | 1.63 | 5.13 | 1.60 | 5.39 | 1.47 | 5.28 | 1.61 |
| Rest. | 18 | 6.78 | 0.55 | 6.28 | 1.45 | 6.33 | 1.03 | 6.67 | 0.69 |

| Effects | F | df | P |
|---|---|---|---|
| Setting | 9.56 | 2,217 | <0.000 |
| Attribute | 5.67 | 3,651 | 0.001 |

*Figure 3*

Dr Meiselman said that another variable factor in his investigations into food consumption was the issue of variety.'It is commonly thought that people eat more when there is a variety of choice.' But the definition of variety is a complex one: is variety to be found within one simple food such as lemonade, or one complex food such as stew? Or within one plated meal, or within a two-course meal or a three-course meal? Or across one day, across all meals for one week, or across all meals for one week? Across weeks, months or years?

Dr Meiselman and his colleagues have done studies showing the difficulties of making simple statements about variety and monotony with regard to foods and menus. In one study, a 'monotony group' was served an identical meal for five different days, while a 'variety group' was served an identical meal for the start and end days, but different meals for each of the three days in between.

Liking for the food declined in the monotony group, but people in the variety group were eating more by the end of the week. The acceptance level remained high throughout, showing that monotony effects are possible for liked foods. Potatoes were resistant to monotony, where green beans were sensitive to monotony.

Dr Meiselman and his colleagues also analysed data from soldiers and realised that most people eat most food items just once, but a small number of people pick the same food items repeatedly. Comparing quality ratings for the people who chose an item once and those who chose it 12 times was predicted to show a monotony effect for the latter group, but this was not the case: people who were able to choose an item for themselves, even repeatedly, rate it highly. With free choice, there is no evidence of monotony if monotony is defined by reduced acceptance; there is monotony if monotony is defined by decreased frequency of selection.'Depending on how you study monotony and variety,' Dr Meiselman said,'you get different results.'

Dr Meiselman carried out a study with Bournemouth University in 2000, in which army rations were removed from their packaging and served on china plates in the university's training restaurant and its student refectory. In both locations, customers were free to choose their meal (the test meal was one of several choices). Customers were asked to fill out questionnaires after they had selected the test meal, giving ratings of liking and appropriateness.

Diners in the restaurant rated the food more highly than those in the refectory. (*Figure 2*)

Dr Meiselman carried out a similar study at East Carolina University in 2000, in two student dining halls, a training restaurant and a food science laboratory. Customers paid in the restaurant and in the dining halls, and there was no choice in the restaurant or laboratory, but there was choice in the two dining halls.

The same effect was observed in the results: the same food was rated more highly in the restaurant than in the dining halls. (*Figure 3*)

A final study was carried out by Bournemouth University: the same dish was served in ten different UK environments including a school, a university, elderly care facilities, a military restaurant, a hotel, and a private home in the UK. Customers were both paying and non-paying, and most people had their choice of meal.

The results followed the same pattern as the two previous studies: restaurants showed more positive ratings, while institutions showed lower ratings. 'This is the big challenge for institutional food service,' said Dr Meiselman. (*Figure 4*)

Dr Meiselman remarked that this last study had also stratified its subjects into age groups, and found that the highest ratings were given by the 46-65 age group. 'It's not clear to us yet whether these people rate the food more highly or whether they're just more to be found in the locations that produce the higher ratings,' Dr Meiselman said.

Dr Meiselman showed the 1996 Cardello study results against the Bournemouth University study. (*Figure 5*). 'There is a correlation between how good you think the food will be, and how highly you rate it,' he said. 'You have to address people's expectations of your product, because this determines how they will like it. When you expect a food to be good, you rate it more highly, irrespective of actual quality.'

Dr Meiselman went on to make some practical suggestions on how to use the information he had discussed. These included paying as much attention to the environment as to the food and the patient; minimising eating alone; eating in a comfortable situation wherever possible; providing choices; providing appropriate meals in terms of food combinations and preferences; identifying problem eaters for special attention (different groups appear to differ in their level of criticism). He concluded that 'we can't improve the quality of institutional food until we address people's expectations of it.'

Ratings of Overall Acceptability

| Overall Acceptability | | |
|---|---|---|
| **Location/Situation** | **Mean** | **n*** |
| Army Training Camp | 6.6 [a] | 43 |
| University Staff Refectory | 6.6 [a] | 36 |
| Private Boarding School | 6.7 [a] | 88 |
| Freshman's Buffet | 6.7 [a] | 83 |
| Private Party | 7.0 [ab] | 77 |
| Residential Home (elderly) | 7.1 [ab] | 43 |
| Student Refectory | 7.1 [ab] | 33 |
| Day Care Centre (elderly) | 7.1 [ab] | 33 |
| University 4-star Restaurant | 7.6 [b] | 19 |
| Hotel 4-star Restaurant | 7.6 [b] | 32 |

Means [a] are significantly different ($p=<0.05$) from [b]
* 4 subjects did not rate overall acceptability

*Figure 4*

**ROLE OF EXPECTATIONS IN TESTING FOOD IN DIFFERENT EATING SITUATIONS**

| RANKING EXPECTATIONS 1 | RANKING ACCEPTANCE 2 |
|---|---|
| Home | |
| Restaurant | Restaurant 7.63, 7.58 |
| Fast Food | |
| School | Student Refectory 7.09, Boarding School 6.66 |
| Military | Army Camp 6.63 |
| Airline | |
| Hospital | Elderly Residential Home 7.05 |

1. Cardello et al 1996, ratings of expected acceptance.
2. Edwards et al, rating of actual acceptance for chicken a la king at a meal.

*Figure 5*

**Anna Coote**
**Health Policy Director and Sustainable Development Commissioner, The King's Fund**

Ms Coote began by asking the delegates to shift focus from food and nutrition to food and sustainable development. This involved pursuing the goals of economic prosperity, social progress, environmental protection and the prudent use of natural resources, to ensure a better quality of life for everyone, now and in the future. 'I want you to consider the NHS not just as a provider of health services, but as a corporate citizen,' she said. 'It is a huge organisation, the largest in the UK. It has an annual budget of £165bn, and spends £11bn on goods and services each year. That means it has phenomenal power to do good or harm.'

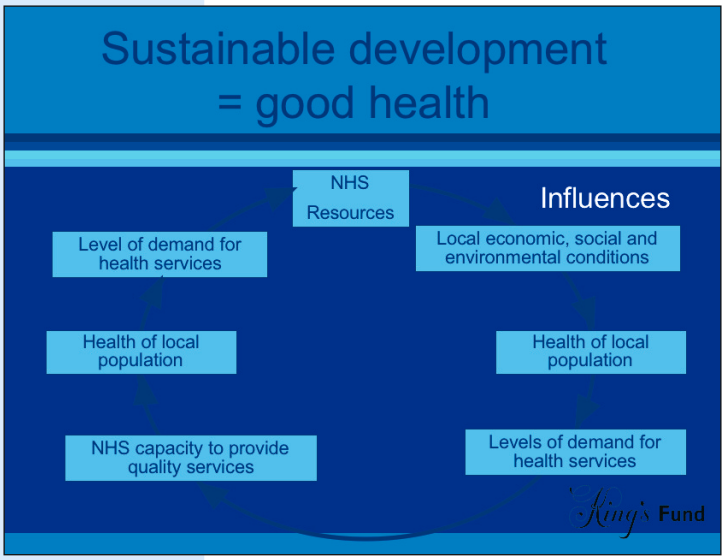


*Figure 6*

The NHS had a primary duty to promote health, said Ms Coote. A speech by Alan Milburn in November 2002 represented a watershed in government thinking by repositioning health policy to give more emphasis to promoting the health of the nation as a whole: 'The time has come for a renewed determination to improve the health of all and to improve the health of the poorest fastest' he said. Rather than focusing on treating illness, this meant paying more attention to 'keeping people away from the NHS,' as Ms Coote put it.

Ms Coote described some of the results of sustainable development including social progress that meets the needs of everyone; effective protection of the environment; prudent use of natural resources; high and stable levels of economic growth and employment. She pointed out that one of the Government's key indicators for tracking progress towards sustainable development was the health of the population.

Sustainable development in health could be seen in terms of a 'virtuous circle', said Ms Coote. (*Figure 6*). Responsible use of NHS resources within a sustainable development framework would directly and indirectly help to improve the health of the population. This would help to control rising levels of demand for health services, so easing pressure on NHS, which in turn would help to improve the general health of the population. 'If all we're doing is trying to treat and cure injury and illness, the NHS cannot ensure its own long-term viability.'

Food production affects the environment, and the environment affects health, said Ms Coote. 'We depend on our environment for our wellbeing.' In a poor environment, there is more pollution, there are food deserts and unhealthy diets, fewer parks and places for exercise, poor housing and busy roads with more accidents. In poor communities there is low employment, struggling local economies, social exclusion, lack of opportunity and optimism, and mental health and wellbeing are undermined.

Sustainable development is concerned with tackling health and inequalities as a whole. 'It's often the poor who get the raw end of the deal. If there's pollution, there's usually more pollution in poor areas. Things that go wrong with the environment tend to affect the poor more.'

What could the NHS do? Ms Coote asked. It could use its purchasing power to promote better health and sustainable development. Food provides a good example of how this might be achieved.

'There are three aspects to this. The first is feeding staff and visitors as well as patients. At a rough guess, one in 50 of the population at large is fed by hospitals. If NHS staff are well-fed, they are likely to be more healthier and therefore more productive. And there's a knock-on effect to the families of those who work in NHS.'

The second aspect is choosing suppliers, Ms Coote said. 'Decisions can be made about what kind of food is to be bought. What is the impact

of food processing on the nutritional value of food, and also on the environment. How much energy is used? How much packaging? What carbon fuels? What's the impact on waste management? And how much pollution is caused in the whole process? These are issues to be taken into account when choosing suppliers.'

The third aspect is where the food comes from. 'Is it produced locally, or does it travel long distances? What's the impact on road accident rates? How fresh is the food when it arrives? If you purchase locally you strengthen the local economy, so you help to lift people from the cycle of poverty and illness. What can be done to support small- and medium-sized firms who may be able to provide food to NHS?'

The food purchasing power of the NHS could be used to influence farming methods, Ms Coote said. Is the food organic? How is it produced? What training practices are used? How much money do farming communities get? What price is the food available at?

SUSTAIN, the organisation that promotes sustainable food production, has given a definition of sustainability in food. A sustainable food system would be health-enhancing; benign towards the environment; would have high standards of animal welfare; would practice fair trading; would be accessible and affordable; and would be grown near the point of sale. 'I wouldn't pretend that local supply is the answer to everything,' said Ms Coote. 'But it can have beneficial effects and it can be encouraged.'

Ms Coote showed two slides outlining the worst and best possible outcomes from any food purchasing policy. As a worst case, NHS food would be fatty, salty and over-processed; unappetising and inappropriate; transported for long distances; heavily packaged and overpriced; grown in conditions that degrade the environment, exploited producers and harmed animals. As a best case, NHS food would be fresh and nutritious; appealing and appropriate; locally-produced; lightly packaged; grown in sustainable conditions; and purchased to support local economies through fair trade.

The definition of value for money is crucial to sustainable development. 'Is it about the cheapest? Is it about how appetising or nutritious the food is? Or is the concept of value for money expandable to include food that's farmed, processed and delivered in ways that improve health over time?'

Food purchasers had to take account of European Union rules that are intended to promote propriety, value for money and fair and open competition. Purchasers must not specify country or area of origin or supply, and they are not allowed to take account of social and environmental effects on society at large. 'Some purchasers may argue that EU rules will not let us do anything we haven't done before,' Ms Coote said. 'But that is not the case.'

'Purchasers may specify that food must be typical of a region or locality; that they must be fresh; they can ask for seasonal menus; and they can take account of the social and environmental impact on their own organisation. So there is quite a lot of room for manoeuvre. However, there are few incentives to interpret the rules creatively.'

Currently, decisions about food purchasing are largely based on cost, Ms Coote said. What are some of things NHS Trusts could do? She suggested designing menus using seasonal ingredients and encouraging suppliers to promote sustainable developments.

She also suggested learning from other European countries. There are examples from Italy, France, Denmark, Sweden, Finland, Austria and Germany, where public procurement programmes encourage local and organic food; and from Tuscany in northern Italy, where local government and subsidies encourage regional cuisine and suppliers with high social standards.

Ms Coote cited the examples of Cornwall, where some food is sourced locally, and two Powys-based hospitals that at one time were unable to use their normal suppliers because of a snowstorm that blocked the roads. 'So they started buying locally. They found the food was more nutritious, the patients liked it, and the Trust had a much better relationship with the suppliers.'

Ms Coote ended her presentation by summarising some problems and solutions. 'The NHS is dominated by targets handed down from the centre. The synergies between sustainable development, health and healthcare are poorly understood. The incentive structures inside the

**"We need a more strategic approach to developing the NHS as a good corporate citizen in all its aspects, to ensure it can sustain its long-term future."**

*– Anna Coote*
*The King's Fund*

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organisation aren't strong enough to promote innovation and change. How can we ensure we do change? In the broadest terms, it's important that we give a higher priority to health, as opposed to healthcare, and particularly to tackling health inequalities. We must promote the practice of whole-life costing, and ask of our policies on food purchasing, catering and nutrition: what are they costing us, directly and indirectly, over five, 10 and 20 years? We need a more strategic approach to developing the NHS as a good corporate citizen in all its aspects, to ensure it can sustain its long-term future. In the end it will show up on the bottom line. That is how we shall know whether or not we have been successful.'

**Loyd Grossman**
**Chair, Better Hospital Food Panel**
**Closing remarks**

Loyd hoped that the delegates had learned a great deal about the interesting, stimulating and productive work being done by hospitals and Trusts around the country and in Europe. He also hoped that delegates had a range of new information to take away and consider in the light of current practices in their Trusts. He reiterated the invitation extended earlier in the day for delegates to review their food and nutrition programmes as a consequence of having attended the conference.

'We have noticed a tremendous appetite for change today, and we want to harness that,' he said. He promised the delegates a report on the day which would include an opportunity for the delegates to feed back to the Department of Health on what they had heard during the conference and to establish networks to share and develop best practice *(page 2)*.

'We want to practically pursue a lot of the themes that emerged today: for instance, environmental issues, the best places for patients to eat, 'Protected' mealtimes, nutritional screening, housekeeping and so forth. If you let us know your thoughts, we will bring interested parties together in networks and help them to formulate pilot programmes.'

Loyd promised the delegates a further conference in the later part of the year to report on progress.

The conference closed at 4.30pm.

*The conference divided into two streams:*

## Stream One: Food

**(page 11)**

*Chair: Joan Rogers, Chief Executive, Tees & North East Yorkshire NHS Trust*

## Stream Two: Improving Nutrition

**(page 18)**

Chair: Simon Allison, Director Clinical Nutrition Unit, Queens Medical Centre, Nottingham

*Chair: Professor Marinos Elia, Professor of Clinical Nutrition & Metabolism, Institute of Human Nutrition, Southampton University*

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# Stream One: Food

***Chair: Joan Rogers, Chief Executive, Tees & North East Yorkshire NHS Trust***

**Paul Cryer**
**Head of Hospitality Services, NHS Estates**
**'Improving quality by design'**

Paul began by stating the necessity of improving the quality of NHS food and food service within the frameworks of patients' expectations and advances in medical technology. 'Many hospitals provide good food standards and some provide good food service. Not too many provide both.'

Paul said that patients are now more like commercial consumers than ever before, and the NHS must acknowledge the idea of 'consumer sovereignty' and create lifelong brand loyalty. 'The customer must be at the centre of everything about the business and the business must be flexible around changes in what consumers want. In this way, organisations meet the expectations of their customers and create high levels of satisfaction. The Better Hospital Food programme must be about redesigning the whole system, from farm to fork. Quality in a product can't be engineered – it must be designed into the product on the drawing board.'

Paul mentioned the challenges often experienced in the design, application and interpretation of patient satisfaction surveys. He cited studies undertaken in conjunction with two London Trusts that gave rise to very different results. Answers given by people in the street about their expectations of being in hospital, together with the opinions of patients once they were in hospital, showed significant differences about what is important and the scale of difference in their opinions. NHS managers found it a challenge to accurately rate the outcome of patient surveys when the design of the surveys had been undertaken by patients and not by hospital staff.

Paul outlined several aims for food service programmes in the NHS, including improving nutrition and avoiding dehydration; improving patient satisfaction; reducing waste; and demonstrating value for money. He spoke of a vision for patient food services that was based on a flexible plan that was personalised and easy to understand, and – of crucial importance – one that had been designed by patients.

Paul said that key to the success of food programmes was getting housekeepers into ward teams: 'they are a lifeline to patients in hospital'. Matrons must take charge of standards at ward level. He outlined several examples of good practice, including Darlington, where patients give meals orders to housekeepers who have palmtops on which are kept menus, information about services and nutritional information; Brighton, where vouchers are available for patients who are able to move around the hospital to cash in at the hospital's food outlets; Colchester, where patients can clearly identify who is responsible for food service by the service staff's distinctive and attractive uniform; the same principle is to be found at Leeds General Infirmary, where food service teams wear a distinctive light blue uniform; Kings College, where 'Protected' mealtimes are in operation, meaning that ward teams can fully focus on food service; Northampton, where an a la carte menu choice is delivered to patients' bedsides day or night within 30 minutes; Nottingham, where the maternity wards run buffet-style food service; and Oxford, where posters around the ward show the food choices for patients to choose.

Paul outlined current progress, including high quality dishes on menus, and snacks twice a day, but said that work was only just beginning. He drew examples from other countries' hospitals, including France, where patients are offered a three-course plat du jour menu comprising popular dishes and noted that 80% of patients choose this menu; the Netherlands, where many hospitals offer a la carte menus and a 'mix-and-match' single-use short-line item system operates for snacks; and the US, where bedside lockers incorporate fridges with daily snacks that can be eaten when required by patients or visitors.

**"The Better Hospital Food programme must be about redesigning the whole system, from farm to fork. Quality in a product can't be engineered – it must be designed into the product on the drawing board."**

*– Paul Cryer*
*NHS Estates*

NHS Estates

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Paul went on to discuss thoughts concerning future food and food service systems.

Matrons must have the authority to set and monitor standards; they should be able to make judgements about quality and general performance regardless of who provides the services. 'Rewarding good performance works, and we should look for a model where Matrons can use this mechanism to get incremental improvements across all basic care services.'

Paul referenced Lord Hunt's comments on food purchasing: 'If we buy poor quality food, the taste, texture and appearance of the end product will suffer. We must enhance our standards of inputs to get the right quality of outputs, and patients must be assured that what we buy has been thoroughly checked out by qualified people who take responsibility for the safety of the foods we give to patients.'

Paul picked out the practice of 'Protected' mealtimes as exemplary: 'It does take a lot of hard work to set up but it doesn't cost very much to deliver, and its impact is vast.'

The NHS, Paul said, is not organised as it was at this time last year: 'The devolution of responsibility to the frontline means you have more choice about the success you want to deliver. It means taking responsibility for issues where before you might have been given a number of targets.' He ended with a plea to delegates to 'go from the conference and build on the work that's been done this year. If we can make as much or more progress in the next 12 months, as the NHS has made in the last, patients will really thank us for radically and consistently having improved the standards of food and food service in the NHS.'

**Rick Wilson**
**Director of Nutrition and Dietetics, Kings College Hospital**
**'Hospital Food as Treatment'**

Rick reminded the delegates about the public consultation on the NHS, which led to the NHS Plan, in which better hospital food and cleaner hospitals figured in the 'top five' of public comment. 'It's the first time food came onto the agenda at all, and that's a wonderful thing to have happened.'

Food, Rick said, is the best form of human nutrition, and within the field of clinical nutrition there was a danger of forgetting that food is where people get nourishment – and this route is psychologically, physiologically and nutritionally best.

Artificial nutrition is limited by current levels of scientific knowledge. New discoveries are being made all the time. 'Most people swallow 1.5 to 2 litres of saliva each day. This doesn't happen when we are artificially nourished,' Rick pointed out. 'We eat first with our eyes, nose and ears. It's re-invigorating, being presented with good food. It can inspire recovery.'

Rick asked why it is that hospitals 'often get it wrong', and proposed that the complexity of the service is misunderstood. 'What other service delivers a perishable product of the patient's choice to their bedside at least three times a day?' Comparisons with hotels, he said, oversimplify the task, and are not helpful.

Rick suggested that a whole systems approach was needed for success, with integrated care pathways. This would be a major management challenge, and would involve quality output from a wide staff group very regularly and consistently.

Such an approach was identified in the Audit Commission's recent reports: the food delivery chain is very complex. There are many links in the chain, and many opportunities for error. Strong team leadership and common vision is necessary for success.

Rick talked of the initiatives which must be integrated, including 'Protected' mealtimes, food and nutrition benchmarking, patient power, the doctor's responsibility, and ward housekeepers.

Catering for some patient groups is easier than for others. The challenge lies with frail patients who are more likely to stay longer. The average length of stay is dropping, but the median and the mode are to the right of the mean, Rick pointed out, and significant numbers stay in much longer and cost much more. At Kings College Hospital, there are six patients who have stayed a year or more. The greatest challenge is providing food and nutrition to these patients.

Rick spoke of the need for perspective on food costs: one of the barriers to change is "we can't

afford it',' he said. But at Kings College Hospital, the drug bill has risen over the last three years, while the food bill has stayed the same: 'We are spending six times more on drugs at Kings than on food.' (*Figure 7*)

Rick appealed to Board members amongst the delegates not to lose sight of the fact that food services can close the hospital in hours, kill large numbers of patients and staff, put the CEO in jail and lose the Board and CEO their jobs, and lose stars and dash foundation status hopes. 'Chief Executives are at the top of the liability ladder,' he said.

Food science and food technology is a very exacting science at present, with nutriceuticals and pre- and pro-biotics being developed. 'We are discovering the interaction between genetics and the environment,' Rick said. 'Food is the only thing you put inside yourself in hospital that interacts with your genetic make-up, and with your physiology.' Macrobiotics research is moving ahead very fast. He pointed out that discoveries in the field of pre-operative feeding have led to dramatic impacts on recovery from surgery.

Malnutrition is already costing the NHS millions of pounds each year: if the patient does not eat, the stay in hospital is extended and other patients can't be admitted. 'This is what the taxpayer wants,' said Rick. 'This is the message across Europe.'

The challenge is to help staff understand the interdependence between different parts of the hospital organisation. (*Figure 8*)

'Providing good food shows also that you care,' Rick said. 'Patients feel welcome if you feed them. It's no coincidence that 'nurture' and 'nursing' come from the same root.'

Hospitals can lead the way in institutional catering, and improvements in residential and social care may help to manage demand. The most vulnerable group is nursing home groups – if these other institutions can be helped, this may slow down the hospital admission rate. '50% of emergency admissions to Kings are chest problems,' Rick said. 'If we can improve nutrition, our patients can resist chest infection and avoid emergency admissions.' He appealed to the delegates to lead this change.

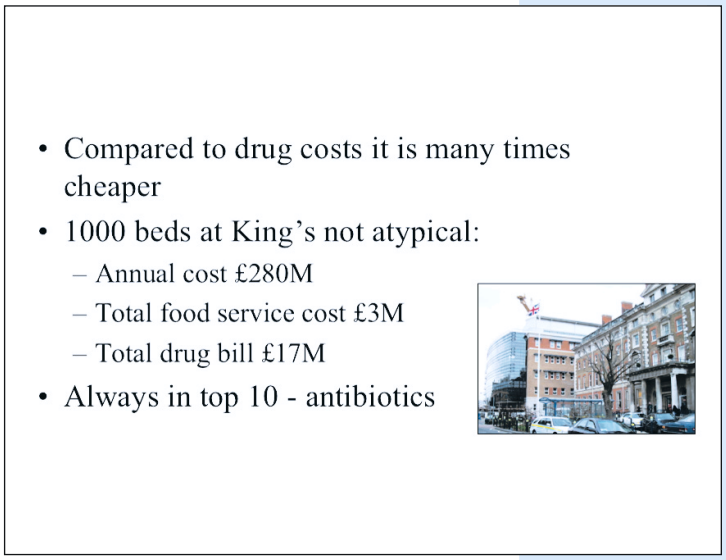


*Figure 7*

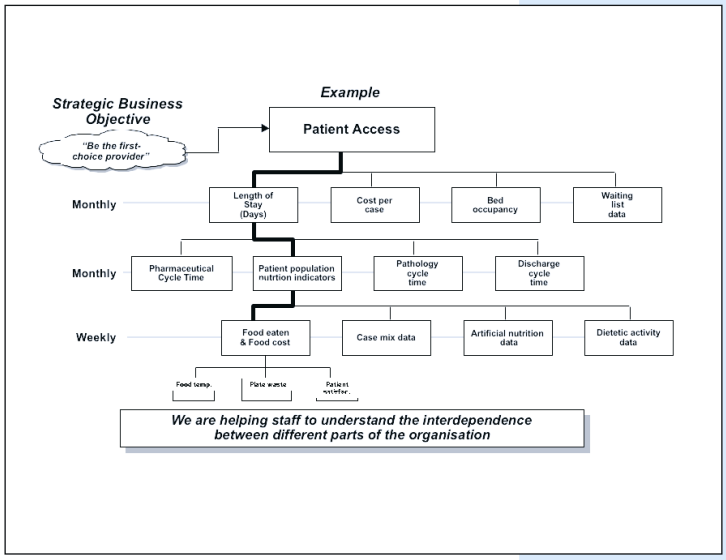


*Figure 8*

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**Mike Wright**
**Deputy Director of Nursing, Guys and St Thomas' Hospital**
**'Modern Matrons and the Essence of Care'**

'We haven't got it all licked,' Mike said to open his session. He reminded the delegates of Florence Nightingale's remarks in 1863: 'Every careful observer of the sick will agree in this, that thousands of patients are annually starved in the midst of plenty... Hospitals should do the sick no harm.'

Mike made no apology for reminding the group of the importance of optimum food and nutrition for us all. Nutrition is important for cell metabolism; to give energy; to build, maintain and repair; to maintain body temperature; to maintain tissue integrity and viability; to prevent infection and disease.

Mike then offered a definition of the word 'matron', but pointed out that the term is often misconceived. He showed images from the film 'Carry On Matron' to illustrate his point.

Mike defined the Essence of Care as a process of identifying current practice against national best practice benchmarks and instituting an ethos of continuous quality improvement.

It is accepted that there are many unacceptable variations in standards across the country. The NHS Plan is in pursuit of a uniformly high standard, by 'universalising the best'.

Mike queried why modern matrons were necessary. They are a product of the NHS Plan, and are being brought back at the request of the public. He listed some of the requirements that modern matrons will fulfil, including resolving clinical issues such as discharge delays and environmental problems such as poor cleanliness; monitoring performance standards and taking corrective action; and being in control of necessary resources, backed up by appropriate administrative support. He asked the question: 'But isn't this happening already?'

Mike said the answer was still divided: there are still complaints about key issues that modern matrons should address. Approximately 35% of complaints relate to direct clinical care (including access to care) and 30% include a component relating to staff attitude or communication problems; many have environmental (especially cleanliness) and food-related components. There are high hospital-acquired infection rates. 'Most people agree that most modern matrons are well-intentioned but they often don't have the time or resources to work differently. They haven't been facilitated or led in the right way.' He emphasised that the modern matron initiative should not just be seen as a re-branding exercise, but that modern matrons are expected to make a real and measurable difference.

However, it is important to put things into perspective. In January 2002, Alan Milburn said 'most people get good care' and 'there are no bad doctors and nurses'. In order to make these observations a continuing reality, the NHS must not rest on its laurels.

Mike told the group that all too often clinical leaders were given responsibility and accountability to deliver without the necessary authority to do so. However, in order for the modern matron initiative to be able to reach its full potential, it is imperative that an equal balance of all three elements exists for these people.

The Essence of Care programme provides a framework, but must be seen as minimum practice standards, and all healthcare team members must be on board if the standards are to become baseline organisational standards. Mike also remarked that the Essence of Care should not just be regarded as an audit tool. Modern matrons are ideally placed to lead the process at ward/departmental level. The standards must be integrated into education programmes for all healthcare workers, and become the everyday standards that clinical practitioners work to.

Mike outlined the opportunities provided by the Essence of Care and modern Matrons. These include the opportunities to: get the basics right for food and hygiene; to challenge traditional, outmoded and inappropriate ways of thinking; to understand the profile of the ward/area and the profile of the patient's day, and redesign where necessary (eg, protected mealtimes, seated dining areas); to link with ward housekeepers; to learn more about what patients want, not what healthcare workers think they want; and to be more creative about how things are done.

He said that the primary challenge for nurses and midwives is to reassert the importance of food and the role that they must play within its delivery. They have a role as health promoters, as patient advocates, and need to balance the requirements of the ill person versus their health needs. They must take further action when normal dietary needs cannot be met, and in some respects must get nurses and midwives to re-connect with food and food services.

Mike then described the role of the ward team in serving food, making sure it is appropriate, encouraging patients to eat, and monitoring intake. 'We must promote normal foods rather than supplements where possible, and we must shift the thinking from seeing mealtimes as a chore towards a fundamental right and need.'

Mike emphasised that it was essential for Chief Executives and executive directors to be fully engaged in the process of delivering food and nutrition to patients. 'Nurses have many conflicting priorities, so they need to be helped to achieve all this.' Mike went on to detail some of the factors necessary to help nurses play their part in making sure patients are adequately nourished. These include planned service developments; caseload balancing: 'We may need to rethink clinical and nonclinical caseloads'; performance measuring: 'Performance is managed to death – we need to think about the positive things too'; and the involvement of patients and service users: 'even though this is difficult sometimes.'

Mike then discussed some of the measures that might help to determine that improvements were being made once programmes were in place. These included diminished complaints (in terms of themes, frequency, and hot spots); better patient surveys and PALS feedback; diminished infection rates and pressure sore prevalence; the use of audit measures such as Essence of Care and environmental audits; and improved recruitment and retention, and a reduction in complaints. 'These are not solely the domain of Matrons, but are challenges for us all.'

'This requires a collaborative, multi-disciplinary process, and is dynamic, on-going work,' Mike said. 'It provides fantastic opportunities to improve many important aspects of patient care, to raise the profiles and job satisfaction of all involved, and to enable us to be more proactive than reactive. It requires a collaborative, multi-disciplinary effort, with everyone valued for their contribution.'

Mike summed up by explaining the positive opportunities that hospital staff now have in this fundamentally important aspect of care. 'In a world where we take away a great deal of a patient's independence, the basics (food and cleanliness) become focal points for them and their relatives. By attending to and reasserting the importance of these fundamental basics, we have a real opportunity to make a difference for our patients and service users.'

**Em Wilkinson**
**Clinical Advisor, NHS Estates**
**'Housekeepers in Action'**

Em introduced herself to delegates. 'Modernisation must be fun,' she said. 'We must enthuse the people we are asking to make these changes.'

Em referred to evidence suggesting the benefits of ward housekeepers. Introducing ward housekeepers improves the entire patient experience. 'A ward housekeeper,' said Em, 'does not just deal with food – they are people with responsibilities and the authority to deal at all levels with ward problems.'

Em discussed the service that patients want, rather than the service that staff think patients want. This includes services organised around the patient's needs, a clean, comfortable and safe environment, good food that a patient can eat, and staff with skills to do the job.

Em quoted the NHS Plan's reference to ward housekeepers, and the basic responsibilities of the job. 'Half of all hospitals will have new 'ward housekeepers' in place by 2004,' she quoted, 'to ensure that the quality, presentation and quantity of meals meets patients' needs; that patients, particularly elderly people, are able to eat the meals on offer; and that the service patients receive is genuinely around the clock.'

Even back in Nightingale's time, fresh air, light, warmth, diet and cleanliness were regarded as the most important aspects of nursing. There must be a team approach to getting things

done, even if the ward sister or the housekeeper are not present.

Em discussed the contact between ward housekeepers, ward sisters and ward teams. 'The ward housekeeper works in partnership with the ward sister and ward team to deliver non-clinical services which support the delivery of patient care.'

Ward housekeepers, said Em, are there 'to support the delivery of clinical care, to give patients what they want, and to deliver the linked agenda between Better Hospital Food, Clean Hospitals, the Essence of Care and Privacy and Dignity.' There is a need to ensure that nurses are freed to nurse: 'Nurses must accept accountability for ensuring patients are fed, and it is the responsibility of the whole ward team to ensure that patients enjoy their mealtime experience. The housekeeper is an important part of that team.'

Em said that the core responsibilities of housekeepers were cleaning, catering and the environment, but also ensuring that linen, portering, catering and supplies are taken care of; meeting and greeting patients; reassuring frightened patients; helping to unpack new patients and buying newspapers if there is no trolley service; making sure flowers are put in vases.'Housekeepers talk to patients about normal things, keeping contact with the world outside the hospital. Little things do matter.'

Em referred to built environments as a sign of respect for patients.'Bad hospital environments make patients think 'If this is how they care for their environment, how do they care about me?'

'We need to be excited about food – if we can't have positive energised attitude to it, how is the patient expected to have a positive response?' Em said. She described the way in which a meal should excite all five senses.

She discussed some particular tasks of the ward housekeeper with regard to food service, and underlined the need for proper plates, cutlery and other details to make food pleasurable, including handwipes pre- and post-meal, linen napkins, the preparation of tables, assisting and encouraging patients to eat, kitchen monitoring and audit, liaising with dietitians and completing food charts, and attending food forums. She stressed: 'Don't put the urinal near the food, and don't use vomit bowls as fruit bowls. Believe me – it does happen.'

'Making sure that patients eat and enjoy food is a crucial responsibility,' said Em. She quoted Leland Kaiser on the reinvention of hospitals: 'The hospital is a human invention and as such can be reinvented at any time.'

'If we always do what we've always done, we'll always get what we've always got. We must embrace change, and learn to do things differently.'

Em detailed some elements of establishing ward housekeepers, including challenging culture, and the rethinking of existing resources.

In summing up, Em said that if the evidence was considered, there should be no option for Trusts about having ward housekeepers. There would be better cleaning standards, awareness of non-clinical support standards, the co-ordination of non-clinical activity at ward level, improved patient satisfaction, and decreased complaints on food, cleaning and the environment, decreased food wastage and decreased clinical waste disposal costs due to waste segregation. Recruitment, clinical time, maintenance of equipment, consistency of service and standards and the morale of staff and job satisfaction would all improve.

Em quoted a ward manager in Hull: 'Introducing the role of housekeeper has allowed us not only to give the fundamentals but also the 'extras' which are so important to the patients' overall wellbeing.'

'Patients are very vocal about the improvements they've seen with ward housekeepers.' In conclusion, Em said, the big question was not 'can I afford to do it?' but 'Can I afford not to do it?'

**Philip Davies**
**Customer Care Manager, Asda plc**
**'Think Like a Customer'**

Philip gave an entertaining and instructive presentation on the key principles adopted by Asda in relation to their customer service programmes. By the mid-1980s, Asda was voted the best-run company in the UK, but by 1990 it

was on the verge of bankruptcy. This happened because Asda lost touch with its staff and its customers.

With the appointment of a new Chief Executive in 1991, Asda's culture was transformed. Hierarchical staff structures were dismantled, with, for example, car parking places being allocated on merit rather than status.

The Chief Executive introduced a 'Tell Archie' scheme, in which feedback forms were distributed to all Asda's stores to be completed by the store staff rather than the managers. Over 40,000 'Tell Archie' forms were returned, and the benefits were twofold: first, that good ideas were generated, and second, that staff morale received a boost from having their ideas listened to.

The Chief Executive also introduced a Volume-Producing Item scheme, in which all store staff were encouraged to pick a product of which they could personally boost the sales. Rewards were offered, including, for the best performers, e.g., the use of the CE's Jaguar for a month with all petrol paid: this again boosted staff morale.

Philip talked about Asda's culture of observing certain animal habits to foster good staff relationships.

'The secret of the squirrel' takes its meaning from squirrels who work hard collecting nuts for winter because they are motivated by their own survival: "If our colleagues can see their work is worthwhile, they'll work harder," said Philip. 'The way of the beaver' considers the teamwork that a group of beavers have: 'There's no head beaver standing over people to tell them what to do – we let our colleagues get on with their jobs and they like the increased freedom and responsibility,' said Philip. 'The gift of the goose' takes as its example a group of geese flying in formation and squawking to each other as encouragement. 'We regularly thank our colleagues for their efforts, which we think can often mean more than pay,' Philip said.

Asda also has an 'Above and Beyond the Call of Duty' (ABCD) award and a 'Going the Extra Mile' (GEM) award for staff who encourage other staff.

Wal-Mart, now the owners of Asda, introduced a 'chant' to Asda, in which a member of staff asks the question 'Who's number one?' to which the staff as a group reply 'The customer, always'. Asda has the motto 'TLC', meaning 'Think Like a Customer' to encourage staff to see customers' experience through their own eyes.

# Stream Two: Improving Nutrition

***Chair: Professor Simon Allison, Director Clinical Nutrition Unit, Queen's Medical Centre, Nottingham***

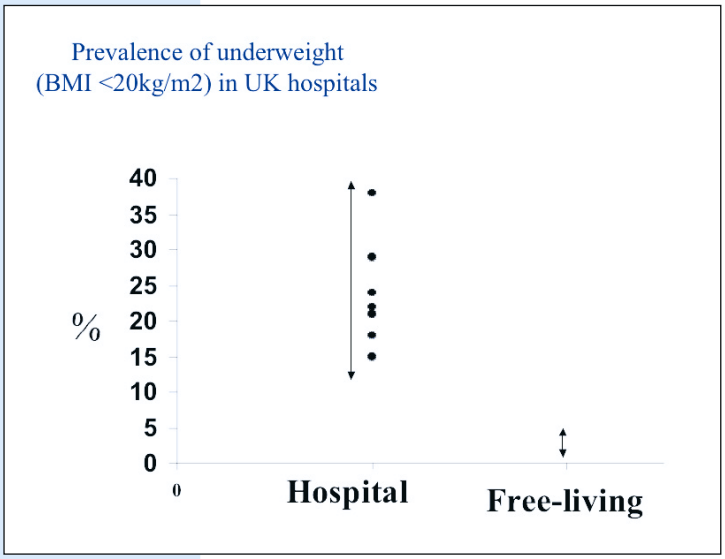


*Figure 9*

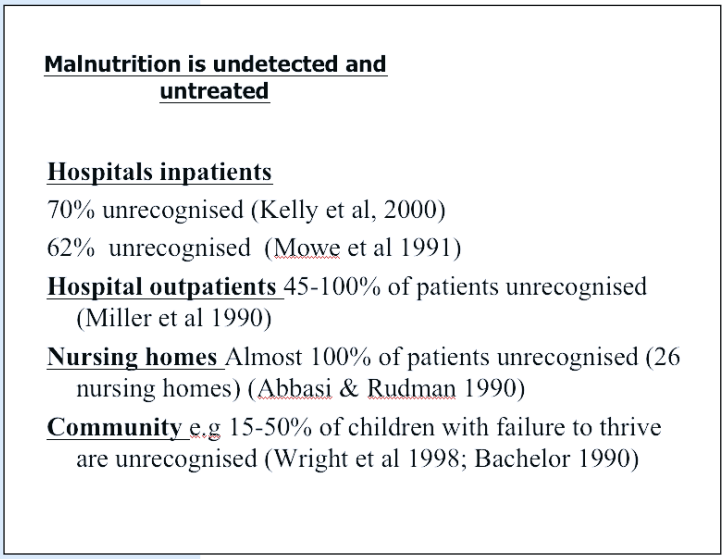


*Figure 10*

**Professor Marinos Elia**
**Professor of Clinical Nutrition & Metabolism, Institute of Human Nutrition, Southampton University**
**'Defining the Problem'**

Professor Elia remarked how well-known it is that nutrition affects psychological and physiological health, inducing weakness and fatigue, apathy, depression and anxiety, and a deterioration in general well-being. Poor nutrition leads to an increased risk of disease and complications, predisposing a patient to disease (eg, infections), accidents (eg, falls) and complications (eg, after surgery). Poor nutrition also delays recovery from illness, increases dependence and increases the length of hospital stay.

It is also known that poor nutrition is particularly high in the hospital population: the percentage of undernourished patients is higher in the inpatient population. (*Figure 9*)

However, less than 5% of the total malnutrition in UK exists in hospitals, and more than 95% in community.

This is also the case with respect to the proportion of illness spent in hospital: only a small proportion from onset to recovery is spent there. But as many as 10m people are admitted each year, so the journey of patients acts as a point at which we can identify those most at risk.

The patient journey often starts before hospital admission, with loss of weight, which often continues to occur during hospital stay, and may even persist after discharge.

Professor Elia demonstrated a 'malnutrition carousel'. Up to 40% of patients are admitted to hospital in a malnourished state; this leads to a 25-100% longer stay in hospital. Up to 70% of patients are discharged from hospital weighing less than on admission, which in turn leads to 25-30% more GP visits and increased prescribing. 'If this is not checked, the cycle can keep going round and round,' he said.

Professor Elia said that perhaps it was of greater concern that much of this malnutrition remains unrecognised and untreated. Studies in UK and abroad show as much as two-thirds is unrecognised, for inpatients as well as outpatients, and it affects children as well as adults. (*Figure 10*)

Professor Elia suggested some reasons for this lack of detection and treatment, including a lack

of awareness stemming from a lack of training and an emphasis on the detection and treatment of disease rather than associated malnutrition; and a lack of organisational infrastructure from hospital to community, which led to a lack of continuity of care and information, and a lack of routine screening for malnutrition.'In order to make changes, it is necessary to deal with both of these,' he said.

Professor Elia raised the issue of nutritional screening: if there is no screening, nothing is identified, and no treatment can take place. In 1992, a Kings Fund report emphasised the need for routine nutritional assessment. Since then a plethora of reports has appeared and gathered momentum (*Figure 11*): the number has increased enormously in last two to three years. Perhaps one of most important ones is draft from The Standards Board for Scotland (Draft Clinical Standards: Food Fluid and Nutritional Care), which suggests that nutritional screening should become a routine in every hospital in Scotland.'This suggestion is currently being considered, and although there are no similar plans in England, it's possible that the Scottish initiative could act as a template for England.'

The malnutrition group of the British Association for Parenteral and Enteral Nutrition has developed the Malnutrition Universal Screening Tool.

MUST is applicable to different healthcare settings, can be undertaken by different healthcare professionals, and can be used on all patients to identify both undernourished and overnourished patients. It can be useful clinically as well as in the public health arena, and can be subject to adaptation according to local policy.

MUST has three components (*Figure 12*): weight loss, body mass index, and acute disease; this is representative of the patient journey. Weight loss represents what the patient has been through, BMI represents the body's status at present, and the acute disease score influences where the patient is going.

*Figure 13* shows the spread of results of individuals assessed using the MUST tool.

MUST has been used to provide a geographical spread of results across the UK: there is a significant north/south divide. The percentage of the

**Reports indicating need for nutritional screening**

- **1992** The King Fund Report. A Positive approach to nutrition as treatment **(King Fund)**
- **1996** Malnutrition in Hospital **(BDA)**
- **1997** Eating Matters Care homes of Elderly people **(DH)**
- **1997** Hungry in Hospital **(Ass Community Health Councils)**
- **2000** Managing Nutrition in Hospital: a recipe for quality **(DH)**
- **2000** Detection and Management of Malnutrition **(BAPEN)**
- **2001** The National Service Framework for Older People **(DH)**
- **2001** Essence of Care **(DH)**
- **2001** Acute Hospital Portfolio: Hospital Catering report **(DH)**
- **2001** National Nutritional Audit of Elderly Individuals in Long-term Care **(Scottish Executive – CRAG)**
- **2001** Care Homes for Older people **(DH)**
- **2002** (in press) Food and Nutritional Care in Hospitals: how to prevent undernutrition **(Council of Europe)**
- **2002** Nutrition in Medicine: a doctors responsibility **(Roy Col Phys)**
- **2003 (in circulation)** Food, Fluid, & Nutritional care **(CSB of Scotland)**

*Figure 11*

| % wt loss (3-6 mo) | | BMI (kg/m2) | | Acute disease |
|---|---|---|---|---|
| score | | score | | score |
| <5% = 0 | | 0 = >20 | | |
| 5-10% = 1 | + | 1 = 18.5-20 | + | virtually no intake ≥5d |
| >10% = 2 | | 2 = <18.5 | | = 2 |

**combined score**

**OVERALL RISK OF UNDERNUTRITION**

| Low | Medium | High |
|---|---|---|
| 0 | 1 | 2 or more |
| NO ACTION | OBSERVE | TREAT |

*Figure 12*

population at medium or high risk of malnutrition in the north of England is 19.4%, as opposed to 12.3% in central England and 11.3% in the south of England. This compares with health inequalities and life opportunities at birth, which could suggest that malnutrition contributes to and is the cause of some health inequalities.

The main risk of malnutrition is with respect to healthcare utilisation (*Figure 14*). Individuals with high risk of malnutrition have considerably greater requirements of healthcare. 'If you do some crude calculations you could say the cost of disease-related malnutrition in individuals of

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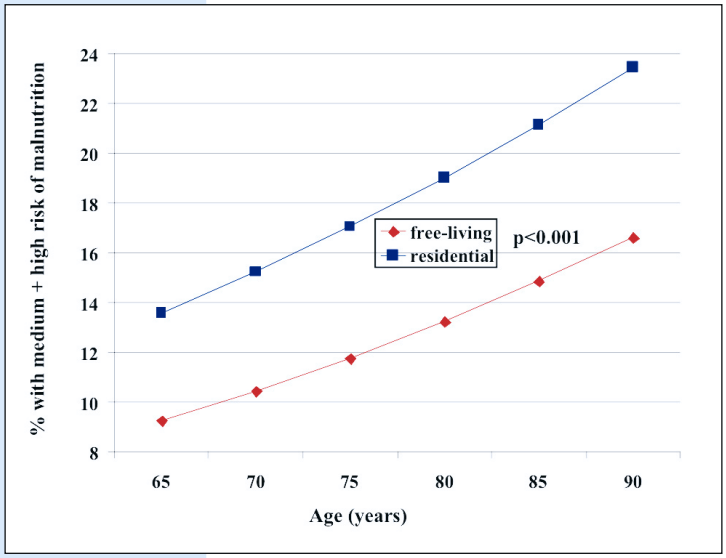


*Figure 13*

**Utilisation of health care resources by malnutrition risk category**

| | Malnutrition risk group | | | |
|---|---|---|---|---|
| | Low | Medium | High | p< |
| Hospital inpatients (12 mo) (%) | 19 | 24 | 55 | 0.001 |
| Hospital stays (12 mo) (n*) | 1.02 | 1.39 | 1.47 | 0.04 |
| GP visit (3 mo) (%) | 57 | 72 | 84 | 0.001 |
| GP visit (3 mo) (n*) | 1.55 | 1.78 | 2.34 | 0.001 |
| Regular clinic visit (%) | 22 | 21 | 24 | 0.88 |

*geometric mean
(Stratton et al 2002)

*Figure 14*

65 and over amounts to £2-4 billion each year, most of which is related to admission to hospitals,' said Professor Elia. 'For every reduction of just 1-2%, this implies a cost saving of £20-40 million each year.'

The evidence is that malnutrition can be treated effectively. Analysis recently undertaken by Professor Elia and his colleagues of 17 randomised controlled trials of supplement feeding shows that mortality can be reduced by a third as a result of supplementation.

The distribution of benefits is also interesting. Individuals with a high BMI gain the benefits, where those that are not underweight show little benefit with respect to mortality. Applying similar criteria, the effect of supplementation on complication rates is shown also to be beneficial. Some of the common complications that can be reduced by supplementation include sepsis, wound and urinary infections, pneumonia, pulmonary failure, wound dehiscence, anastomotic leaks, bowel obstruction and myocardial infarction.

The analysis can also be undertaken in subgroups, in particular categories such as surgical or liver disease or orthopaedic patients.

*Figure 15* shows improvements in body function for hospital and community patients in particular categories.

'With all these benefits, it is not surprising that the length of hospital stay has been reduced,' said Professor Elia. In fact, hospital stay in 11 randomised controlled trials had been reduced by 13 days (27 days over 40 days).

In conclusion, malnutrition is a common clinical and public health problem; but it can be treated. 'Appropriate nutritional support reduces mortality, reduces complications and speeds up recovery from illness,' said Professor Elia.

**Question and Answer**

*Q: Is malnutrition a greater problem than obesity, and is this changing?*

A: In hospital, there are often fewer obese patients than malnourished patients. In the population as a whole obesity accounts for 15-20% of the population, but the proportion in hospitals is rather less because of illness-related poor eating. It's possible to be both obese and suffer from malnutrition: both BMI and weight loss are independent predictive factors, and we must consider both.

Professor Allison commented that an obese person can lose tissue rapidly with acute illnesses, and therefore should be treated as if there was the possibility of malnutrition. On a long-term basis, it is possible to detect overnourished patients and intervene in an appropriate way. 'We should distinguish between the long-term care and the treatment of the individual.'

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*Q: Please tell us more about the supplement regimes that were used in these studies.*

A: We looked for evidence of the effects of solid food, but there were remarkably few intervention trials. So we turned to the use of supplements, mainly liquid multi-nutrient feeds providing 300-500 calories/day of which 15-20% was derived from protein. It may be that the benefits achieved by these supplements occurs because they're more readily available, and easier to give between meals. If there was a system of catering that provided solid food between meals, the same benefits might occur. But liquid feeds feature in these studies simply because the data is available.

*Q: I'm interested in the costs of this. And I'm also conscious that these days people are willing to enter into litigation. Will these costs be added to if patients sue for becoming malnourished in hospital?*

A: We didn't take litigation costs into account. They could add substantially to the overall costs.

Professor Allison commented on his knowledge of legal cases proceeding at present against community and mental health facilities for malnutrition. 'I think this will increase. As soon as the public realises food is an important part of nutrition, we will be seeing more cases of malnutrition-related litigation.'

*Q: How could we make nutritional screening a more key part of our patient admission routine? Or even mandatory?*

A: If a procedure becomes mandatory, just like taking the pulse and blood pressure, its impact will be so much greater. The difficulty is to get the authorities to make it mandatory. It will probably become mandatory in Scotland later this year, and I hope it will be the same in England. But this depends on local enthusiasm, and extent of commitment to a process that can be shown to actually work. That's the challenge we have.

*Q: How do we allow for families who bring food in for their relatives?*

Improvements in body function in hospital and community patients

| COPD | Elderly | HIV / AIDS | Liver disease | Surgery |
|---|---|---|---|---|
| improved respiratory function | reduced number of falls | improved cognitive function | lower incidence of severe infections | greater wound healing |
| increased hand-grip strength | increased activities of daily living and mobility | immune function changes | improved liver function | less fatigue |
| increased walking distance | improved immune function | | | less loss of muscle strength |
| | increased well being | | | |

*Figure 15*

A: For certain groups of patients, the information available suggests that food brought in by relatives can increase food intake.

Professor Allison remarked that he and his colleagues had undertaken a study showing that elderly patients ate as much between meals as at mealtimes, and the extra food was provided almost exclusively by relatives.

**Dr Orla Zinck**
**World Health Organisation Centre for Mass Catering**
**'The European Perspective'**

Dr Zinck began by saying that if delegates were to read the European newspapers, they would find a common view that food in hospitals has a low reputation. 'It is the same all over Europe: food in hospitals is a low priority.' He cited the low pay, the lack of contact with the patient, the poor architectural planning and the low standard of education and training amongst catering staff as reasons for the situation.

Dr Zinck pointed out that a higher food intake does not necessarily always mean a shorter stay in hospital. 'It is proven that eating in hospital is not always safe. Food borne disease is a problem all over Europe. And yet it should be safe to eat in a hospital.'

Patient stress, fear and anxiety are all contributing factors to the patient's lack of desire to eat. Healthcare professionals take a blasé attitude to the feeding of patients, but 'food carries

**"The cost of disease-related malnutrition in individuals of 65 and over amounts to £2-4 billion each year... For every reduction of just 1-2%, this implies a cost saving of £20-40 million each year."**

***– Professor Marinos Elia Southampton University***

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**A success story**
**University Hospital of Copenhagen, Children's Cancer Ward**

| | |
|---|---|
| Before new kitchen (25 children / 217 days) | 44.8% |
| After new kitchen (20 children / 111 days) | 70.8% |

Energy intake in % of recommended daily intake for healthy children (FAO/WHO, 1985)

P <0.001. The results have been corrected for significant influences from fever, anaesthesia, radiotherapy, corticosteroid treatment and energy given by dextrose IV by regression analysis before comparison.

*Figure 16*

a lot of values,' said Dr Zinck. 'It brings people together and has many social and personal implications.'

Too many modern hospitals, remarked Dr Zinck, produce their food in a kitchen far away from the ward. Too many modern hospital wards have such small kitchens that only tea can be provided on the ward. Ordering systems are inflexible: slow to respond, with fixed eating hours, no dining rooms and inappropriate portion sizes.

The Council of Europe recently published a report and guidelines, called Food and Nutritional Care in Hospitals and How to Prevent Undernutrition. Countries involved included Denmark, Finland, Germany, Norway, Sweden, Switzerland and the UK; problems highlighted in the report were similar for all these countries.

Barriers to preventing malnutrition or undernutrition included a lack of involvement from hospital administration staff who didn't take responsibility for the food served; a lack of clearly defined responsibilities in planning and managing nutritional care; a lack of education about nutrition; and a lack of co-operation between different service groups including nurses, matrons and catering staff.

Dr Zinck cited changes made by the University Hospital of Copenhagen to its children's cancer ward food and food service as an example of good practice. (*Figure 16*)

The changes focused on redesigning the ward kitchen, a more informative and child-friendly menu, flexible eating hours, a relaxed eating environment and the regeneration of food on the ward. 'Before the changes, food intake was 45%. After, intake increased to 70%,' Dr Zinck said.

'If you want to change food nutrition and catering in hospitals, you must change attitudes,' said Dr Zinck. 'The priority of food must be raised to high status.' He recommended the introduction of new technology, architecture and environments; flexible food service systems; and varieties of choice and taste. 'But it is very difficult to get systems that are weighted towards clinical administration to focus on such a simple thing as food,' he said.

Professor Allison commented that there are several examples of Dr Zinck's recommendations, including the main teaching hospital in Copenhagen, 'where it has been clearly shown that lack of food intake is not an inevitable consequence of serious disease.' It is possible to intervene and raise the percentage intake almost to meet requirements. Furthermore, the data suggests that this reduces the amount of weight loss and improves the clinical outcome.

**Question and Answer**

*Q: Is there any stratification of patients involved in such studies? The highest-risk groups get most benefit from intervention. In this country, how can we combine the BHF programme with a social experience of dining for acute risk patients?*

A: (Professor Allison) There are obvious differences between patients who are admitted for minor inpatient procedures, who are already well-nourished, and those suffering from serious diseases together with disease-related undernutrition. 'It is very important that patients are assessed for their needs, and their needs are fulfilled. There are some patients who may benefit from directly-cooked food from a ward kitchen, which is cost-effective sometimes. But that's a very small group of patients, and to put blanket high-cost resources into feeding everyone that way could be a waste of resources. This is part of our message.'

**"If you want to change food nutrition and catering in hospitals, you must change attitudes. The priority of food must be raised to high status."**

***– Dr Orla Zinck***
***World Health Organisation***

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One aspect of the issue is the patient's experience, and the other is clinical effectiveness. 'Usually these go together, but they may not,' said Professor Allison: 'if the patient likes the food they're more likely to eat it, but there are more complex factors at work there.' He cited a recent study on hospital food appreciation scoring, showing that those who were identified as overweight were given a healthy eating diet, and did not enjoy the experience. 'In some instances, these aspects are in conflict, but in a malnourished patient they usually work synergistically.'

*Q: Could you recap on the simple interventions?*
A: Change the kitchens, the environment, the meals.

*Q: Studies have shown that the enthusiasm of the person providing the care makes the difference, and the vehicles through which that enthusiasm is expressed makes less difference. Do you have any measure of enthusiasm? Is it more or less important than moving furniture around?*
A: Enthusiasm is important. You're talking about changing the culture.

*Q: Many patients are now going to France for surgical procedures, and the anecdotal evidence is that food is much better there.*
A: It is better to produce your own food locally, which is the situation for many hospitals in France.

*Q: Do you have any indications of the financial effect of doing this? At the end of the day we have to employ people who do a quality job, and that means paying more.*
A: The results from the children's cancer ward in Copenhagen show that food is produced more cheaply now than when it was produced in a central kitchen. It depends on your baseline.

*Q: Did that include the set-up costs of the local kitchen?*
A: No. The payback rate on the capital cost was five to six years. My experience in changing catering systems suggests that payback rates sit between three and eight years.

***Chair: Professor Marinos Elia, Professor of Clinical Nutrition and Metabolism, Institute of Human Nutrition, Southampton University***

**Nutritional Assessment Survey**
**NHS University Hospital Trust**

| BMI | Care of Elderly % | Medical % |
|---|---|---|
| <18.5 | 23.5 | 18.2 |
| <20 | 17.6 | 14 |
| >25 | 17.6 | 23 |
| >36 | 18 | 10 |

*Figure 17*

**What all doctors need to know**

- The clinical importance of a balanced diet, of patients being overweight or underweight or being deprived of nutrients
- Recognise nutritional deficiency or excess
- Nutritional care depends on teamwork between healthcare workers in different disciplines
- Communication within & between healthcare teams in the hospital & community is essential
- Ethical considerations – doctors may be called upon to make decisions about nutritional treatment if patients unable to take such decisions for themselves

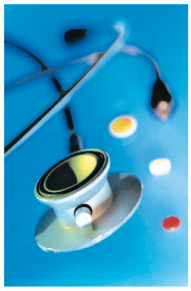

*Figure 18*

**Professor Peter Kopelman**
**Professor of Clinical Medicine and Deputy Warden, Barts & The London, Queen Mary's School of Medicine and Dentistry, University of London**
**'The Doctor's Responsibility'**

The report 'Nutrition and Patients: a Doctor's Responsibility' was published last July by the Royal College of Physicians (RCP). The RCP oversees the education of physicians and doctors as well as consultants. The report was directed at doctors, but is relevant to all healthcare professionals. On the right is a list of members of the report's working party: the report was not uniprofessional in direction, and the working party included representatives from dietetics, nursing, hospital catering, and all areas of provision of care to patients. The RCP puts emphasis on standards of care, and nutrition requires the highest standard of care.

The report covered the benefits from improved nutrition, including reduced rate of complications, reduced mortality, morbidity and reduced length of hospital stay.

The basis of the report is that doctors' knowledge of nutrition is poor, and it issues a 'wake-up call' to the profession.

Professor Kopelman cited Professor Allison's earlier session, which clearly highlighted the problem with undernutrition, but said that the message that must go away with delegates today is that malnutrition covers both undernutrition and overnutrition.

Up to 40% of hospital patients and 10% of patients in primary care, and importantly 12.4% of the community population over 65, and 20.5% of those in residential care, are undernourished; and presently about 60% of the adult population is overweight and about 20% is obese. The message to doctors must be to maximise and identify that opportunity to influence patients and communicate with patients and other staff and the community about nutrition.

The data in *Figure 17* was collected by a medical student from Professor Kopelman's own Trust in October last year. The study considered a care of the elderly ward, and an acute medical ward, looking at all patients who were under- and over-nourished. 70% of the Trust's population were found to have some degree of malnutrition.

'Interestingly, as expected, there was a significant number of older patients who were undernourished,' said Professor Kopelman. 'What was new was the number of older patients who were frankly obese. If you look at length of stay of

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those individuals, their stays were significantly longer than other patients.'

The RCP report tried to identify what doctors need to know about nutrition (*Figure 18*).

Doctors are part of a team providing nutritional care, said Professor Kopelman. Nurses are very important; they have the responsibility for ensuring patients are adequately fed. There is the opportunity for nutritional screening, 'and in our own Trust the nurse screening on elderly wards is superb.'

Dietitians are responsible for quantitative estimates of what patients eat vis-à-vis recommended standards, and the management of over- and under-nourished patients. 'We have too few dietitians to provide for all patients who require their services,' said Professor Kopelman.

Finally, SALTs and pharmacists are part of the team – they assess swallowing and other difficulties, and administer medicines and supplements – but they are not always recognised as such by doctors.

'If we're gong to alter doctors' views, the only way is by putting nutrition very firmly into clinical governance,' said Professor Kopelman. He remarked on the importance of recognising and taking account of previous initiatives and reports at Trust and community level: 'We don't want to reinvent the wheel.' Groups and initiatives included the NHS Plan, the Malnutrition Advisory Group of BAPEN, the Essence of Care, the National Service Frameworks (CHD, Older People, Diabetes) and the NHS Cancer Plan.

'Importantly, if we're to establish nutrition into clinical governance, we need a steering committee in every Trust to advise the medical director and the chief executive. It's just as important as the medicines committee, which already has a high profile in the Trust,' said Professor Kopelman. He recommended that any steering committee should include a dietetic manager, a pharmacy manager, the director of nursing, the estates director, the quality director, the business manager, health promotion personnel and a doctor.

Professor Kopelman went on to outline other important aspects of the establishment of nutrition into clinical governance, including nutritional quality, nutritional screening, assessment and monitoring, feeding practices, referral protocols, nutritional support protocols, audit protocols and education and training.

**Recognition of Nutrition in Clinical Governance – Performance Monitoring**

- Fair access – nutritious and acceptable food
- Effective delivery of appropriate care – nutritional assessment and referral
- Patient/carer experience – perception of quality of nutritional care
- Health outcomes – nutritional risk, post-operative recovery
- Efficiency – length of stay, prescribing of nutritional supplements
- Health improvement – re-admission rates, mortality rates

*Figure 19*

**Education and Training in Nutrition – Doctors in Training**

- Nutritional screening should become mandatory part of clinical assessment of all patients
- Postgraduate examinations and assessments should recognise this
- Greater emphasis on nutrition in general professional and specialist training – include within curricula
- Opportunity for intercollegiate group on nutrition to take this forward with involvement of all health professionals
- Need to increase training opportunities in nutrition – current good practice includes nutrition support in gastroenterology, intercollegiate nutrition course and sub-specialty training for metabolic medicine

*Figure 20*

Professor Kopelman listed some targets for performance monitoring. (*Figure 19*)

'The education and training of doctors is critical. We have to start at undergraduate level and doctors already in training, and go into continuing professional development.'

Professor Kopelman detailed an advance on the undergraduate front: the General Medical Council, which oversees the curricula of medical training, has a section in its 2002 publication 'Tomorrow's Doctors' that begins: 'Doctors must

also know and understand the role that lifestyle, including diet and nutrition, can play in preventing disease.' Nutritional topics are excellent examples of applied science in clinical practice, public health and health promotion – making a 'thread' across the entire course.

(*Figure 20*) 'If we look to doctors in training, I would support the idea that nutritional screening should be part of the clinical skills that doctors are taught. If this is to happen, examinations should recognise that, and the membership of the Royal College of Physicians should include such assessment,' said Professor Kopelman. There should be greater emphasis on nutrition in general and specialist training. There may be opportunities created by an inter-collegiate group of representatives from all the Royal Colleges. Finally, we need to increase training opportunities in nutrition.

'The RCP has an important role to play in continuing professional development, and we need to see more training courses available for all healthcare professionals.'

Professor Kopelman summarised the doctor's responsibilities. These are (i) educational: a doctor is seen by the public and patients as providers of information and advice on food, health and nutrition; (ii) advisory: a doctor should influence food and nutrition policy in their own NHS Trust and community; (iii) organisational: a doctor should initiate or contribute to programmes on nutrition working with others in healthcare organisations; and (iv) investigatory: a doctor should research into nutritional topics as part of their work with support from NHS research funding.

In summary, Professor Kopelman said that it was highly important that these concerns are addressed. 'The Royal College of Physicians takes seriously its responsibility to ensure that the recommendations of [the report 'Nutrition and Patients: A Doctor's Responsibility'] are addressed – to do otherwise is not in the interest of patients or society as a whole.'

**Question and Answer**

*Q: In your geriatric wards, there is screening. Why there and not on medical and surgical wards?*

A: Two points. I am very impressed how well the team works together on the elderly wards, which are associated with longer-stay patients. But also I'm impressed with their standards of care and teamwork, and I'm sure that's why nutritional screening is easier to introduce and keep going. In acute wards, everything is much more fragmented, and patients land for a shorter spell of time. I don't think this is an excuse – screening needs to be done at the time of arrival. The only way to achieve this is to get it into the Trust policies, and this is a major issue that relates to clinical governance.

*Q: I like the sound of the committee and would like to see something similar in mental health hospitals as well. Our patients stay with us longer, and the drugs they take tend to be associated with obesity. Are there any reports aimed at mental health facilities?*

A: No, but I entirely support what you're saying. It's a problem. Nutrition must be recognised as an important element for the purchasers or commissioners of healthcare. The RCP report covers the whole of the healthcare sector, but physicians' work is mostly hospital-based, so there is some bias in way it's been written.

*Q: This report is very much welcomed. You've been implementing this in your own hospital – can you give me some practical ways of doing that and some outcomes?*

A: First, it's a good idea to do some auditing. Second, you need to get on board all those who are interested in nutritional care. There will be considerable enthusiasm within the hospital to improve the wellbeing of residents. The medical director and director of nursing need to be influenced. Once you've got them on board, things will begin to move. It's a bottom-up approach. Those who are on frontline who are most influenced by suggestions; middle management are more distant and have other priorities and targets. Senior managements can be influenced, but the real issue is about getting it into the culture of the Trust.

*Q: I tried once to get this principle established. Nobody took much interest. Then I went to a senior*

*medic and asked him how he felt if he didn't have breakfast or lunch and was then asked to work in afternoon, and things changed overnight.*
A: I'd agree, and unfortunately in this day of medical litigation, where newspapers carry headlines of patients starving in hospital, that kind of approach has a major impact through hospitals.

Professor Elia asked for a show of hands as to whether delegates had come from a hospital with a steering committee. The results showed slightly less than half the delegates had a steering committee. 'If we had asked the same question a few years back, it would have been far far fewer,' said Professor Elia.

*Q: Students say 'Unless I'm asked questions about nutrition it doesn't count.' What steps is the RCP taking to incorporate these things?*
A: I am the senior examiner for the MRCP, so if I can't make it happen, nobody can.

**Professor Simon Allison**
**Director, Clinical Nutrition Unit, Queens Medical Centre, Nottingham**
**'Options and Solutions'**
Professor Allison began by reiterating that malnutrition is common on admission to hospital, that it tends to get worse during a hospital stay, and that in most cases it remains undetected and untreated. This impairs recovery and increases costs, and the majority of doctors and nurses don't understand malnutrition.

Nutritional care is an important part of a patient's overall care. 'You can't come along and be a nutritional specialist, saying 'this patients weighs so much, they need x number of calories per day' because unless you understand the clinical circumstances of a patient and how those circumstances all fit together, you can go wildly wrong,' said Professor Allison. 'Not least because your concern about nutrition may not be appropriate. There must be a comprehensive view of the overall situation. This implies you are working closely with all the other people involved with this patient – and this comes back to teamwork.'

Professor Allison told the delegates that those amongst their number who were worried about young doctors' knowledge of nutrition should rest assured, 'because their knowledge of other things is even worse.' Recent research done by Professor Allison and his colleagues on 200 junior doctors found that 95% of intravenous fluid prescriptions were left to the junior doctor to prescribe; but 75% of junior doctors didn't know how much sodium there was in a litre of saline. 'There are several serious inter-related problems here,' said Professor Allison, 'we shouldn't just see nutrition in isolation.'

Most patients depend on hospital food for their nutrition, rather than supplements. 'Of course we wish to improve the patient's personal experience, but if we want to improve their clinical outcome, we need to pay attention to the science, to provide more appropriate nutrition targeted to that patient's needs.'

Professor Allison said he had been dismayed when catering was put into the NHS's Estates section, signalling it was regarded as a hotel rather than a health function. 'It's recognised we must all come together, and Estates have just as much responsibility for the care of patients as clinical staff.'

Professor Allison pointed out that the problem has been in evidence since the time of Florence Nightingale. He referenced the 1994 Pennington study, showing that little had changed.

He went on to outline some areas for change. 'We've touched on better training and education of doctors, but I think that's fundamental to the whole business. And we've touched on the question of policy and culture, and changing the actual culture of health authorities and Trusts to really understand that this is not just about pleasing the customer, it's about making people better more quickly.' Professor Allison also touched on catering: 'We've already mentioned organisational structure and co-ordination. Therapeutic committees have in the past focused us on evidence-based treatment, but they have also saved us a lot of money. I recommend that you invest in the nutrition team. There are paybacks.'

Professor Allison reminded delegates that nutritional policy must be part of the Trust's overall patient care policy, and that services must be integrated and co-ordinated. 'It's no use if your dietetics department is at the other end

**"Unless you understand the clinical circumstances of a patient and how those circumstances all fit together, you can go wildly wrong... There must be a comprehensive view of the overall situation. This implies you are working closely with all the other people involved with this patient – and this comes back to teamwork."**

***– Professor Simon Allison Queen's Medical Centre***

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of the hospital, and the dietitian is a stranger. If within your hospital you look around for people with expertise, you can start to generate some kind of organisation which will move things forward. This really means that catering and dietetics must come together. The catering officer has to be an important person influencing policy, and the chief dietitian must have an input into catering policy. Nutrition support teams come in for parenteral or enteral nutrition. The complication rate for inexpert application of this technology is enormous: in fact, nutritional support teams pay for their salaries two or three times over in what they save. There was also a need for a purchasing group, said Professor Allison, and a multidisciplinary steering group should oversee the whole activity.

Professor Allison highlighted the need for hospitals to work with the community in tackling malnutrition and obesity. 'There tends to be a rather patchwork development here. In the management of obesity, hospitals will never do more than scratch the surface. The major part of that is in the community.'

Patient care also plays a role in nutrition, said Professor Allison. 'I was asked to see a patient last week, to consider giving her artificial nutrition. When I went to see her, her food tray was some distance from her bedside. I eased her up and put her lunch in front of her, and she ate most of it. She just needed a little bit of help. These things are not glamorous, but they're crucial to the success of the whole enterprise.'

He also stressed the need to consider the patient's nutritional requirements. 'For the average patient, the energy requirement is about 30 calories per kilo per day, so the total energy requirements shouldn't be too hard to deduce. If catering reaches 1.3 times the energy requirement, this would maintain weight.' He referenced the Danish study, which showed that if catering could provide 1.5 times the energy requirement, the majority of patients gained weight. 'Weight loss is not an inevitable consequence of disease.'

Professor Allison referred to a study done recently with elderly patients whose food intake was monitored. The patients left 42% of the food on the plate, which was therefore wasted, resulting in only 70-75% of energy and protein being met. When asked, the patients complained that portions were too large. By decreasing portion size and increasing energy density, wastage declined and energy intake rose so that it met 96% of estimated requirements. 'Each patient group has its own requirements, we just need to study and adapt menus to the patient group.'

Professor Allison had also had experience of a ward that retained its kitchen, the only ward in the hospital to do so. A cook asked long-stay patients with recoverable but difficult conditions what they would like to eat each day, and these meals were produced. 'It made a fantastic difference. We were able to avoid extra feeding, and the savings on that paid for the cook. The wastage rate was just 10%.'

On the question of artificial nutrition, Professor Allison said this demanded special teams, but only 30-40% of hospitals in the UK have such teams. 'There are at least ten publications in the literature showing dramatic reductions in complication rates with nutrition support teams.'

Professor Allison also recommended the use of diet technicians, citing a study done in Ipswich, where two diet technicians were attached to two HCE wards, and saved many thousand patient days with savings of about £90,000 per year. 'Support dietetic technicians may have a place supporting dietetic staff. We and other hospitals have identified a nutrition link nurse on many wards.'

In conclusion, Professor Allison said, there must be an overall policy, and under that policy there must be co-ordination and integration with a steering group which determines policy and protocols, while keeping the practice running smoothly, monitoring and auditing, training and educating. He finished with a plea for designing solutions 'from the bottom up rather than the top down: those in the front line understand far more than we in our offices ever do about the real issues out there.'

**Question and Answer**

*Q: Dietitians often don't get involved in planning menus. Is this right?*

A: Dietitians should be involved in the planning of the menu. There are too few dietitians spread

too thinly. I see their role in helping and facilitating nurses. Maybe we could solve the shortage of dietitians by creating assistants or dietetic technicians. In Denmark, where dietitians have a less scientifically-based training, they've done better. Our dietitians are nervous of their professional identity, but they needn't be.

*Q: If a patient is very ill, how do they get across their dietary requirements?*
A: I would tread warily on that. I invite dietitians in the audience to tell us what they do?

A from audience: I think it's difficult if you don't have an understanding of general nutrition. One of our routes is by using education and training sessions for patients as well as for staff. How you produce the literature and information, both at ward level and what you do within the kitchen and catering areas, these are both important. Professor Allison remarked that his unit had run classes for patients to educate them in dietary matters.

*Q: People are being very much driven down the food-only route, rather than supplements, and I would encourage a complementary approach. My biggest concern is vis-à-vis energy and protein requirements - how to do you address vitamin requirements?*
A: Routine vitamin supplements in some hospitals patients, such as the elderly, may help. You are right in saying the various ways of feeding are complementary. The total intake has to be nutritionally adequate at the end of the day, and if it's composed of supplements, food and enteral feeding, et cetera, then so be it. We're trying to achieve those nutritional targets by whatever means we can, but food should be the first attempt. It's no good giving up on food.

*Q: I'm interested in ward kitchens for long-stay patients. Have you any evidence of outcome benefits or do you know of any publications on this?*
A: We did an audit of wastage from the kitchen. These aren't just long-stay patients, but most have complications – anorexia, sepsis, et cetera. If you send them something up that's been cooked two hours ago they just reject it, but if you give them something fresh they eat it. You then don't have to give that patient artificial nutrition. If the patient won't eat what you give them, you have no alternative but to give them supplements or artificial nutrition.

**Professor Alan Jackson**
**Director, Institute of Human Nutrition,**
**Southampton University**
**'Options and Solutions'**

Professor Jackson began by remarking that he considered the conference to be a watershed. The report of the Royal College of Physicians and the recommendations from the General Medical Council were significant, he said, but the extent to which the delegates were coming together in terms of thought processes and the totality of care was even more significant.

Professor Jackson said his first question concerned whether or not what was done in nutrition was in any way different to what was done in the rest of medical practice. He concluded that it was, but should it be? He said that the fundamentals of life were oxygen, water and food. In each respect there were regular, special and highly specialised forms of intervention, depending on the patient's intake of each. 'And yet nutrition, the third basic requirement, is taken for granted. We should place our general clinical practice in terms of how we deal with nutritional failure on the same level as how we deal with oxygen and water failures. You've heard that a large proportion of hospital patients are malnourished. If this was the case with cardio-respiratory failure or renal failure, we'd be very embarrassed not to do something about it. But we allow patients with nutritional failure to elude us.'

Professor Jackson said he found amazing 'the extent to which we know simple practical measures but are unable to communicate them and put them into practice.' He referred to the mortality rate for malnourished children, between 30 and 60%, 'which hasn't changed over time. But the World Health Organisation has a ten-point plan to bring mortality down within weeks if not days which has been shown to reduce mortality to just 10-15%. We have effective interventions which are not adequately understood across the profession.'

**"A large proportion of hospital patients are malnourished. If this was the case with cardio-respiratory failure or renal failure, we'd be very embarrassed not to do something about it. But we allow patients with nutritional failure to elude us."**

***– Professor Alan Jackson***
***Southampton University***

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Professor Jackson accused hospitals of 'tinkering to bring about piecemeal change'. He said that what was required was a change in culture, and that the missing element in that culture-change was a new ethos for nutritional care. 'It matters, it can make a difference, and it ought to be active in every part of the patient's care.'

Professor Jackson said that what the conference had heard during the day suggested that all the critical elements – leadership, standards and protocols – were in place. 'We must bring these together to move forward.'

'Doctors have an overblown sense of their own self-importance because they have difficult decisions to make, and it is clear they have to be won over. At least we have to make sure they're not obstacles to progress. Their opinion is highly respected. They play a powerful role in enabling and disenabling this programme to move forward.'

The Department of Health released an 18-point curriculum ten years ago, covering the principles of nutritional science, public health nutrition and clinical nutrition and nutritional support. Professor Jackson recommended that in each healthcare profession, these bulletpoints should be made available as a core of education on which practice should be built.

There were also issues relating to undergraduate and postgraduate training, said Professor Jackson. At postgraduate level it was critically important that the environment provided experience of leadership and role models and standards of care.

Professor Jackson also described himself as 'delighted' that the General Medical Council now requires all doctors to be minimally competent in nutrition if they are to practice. He referenced the formation of an intercollegiate committee on nutrition formed from all the Royal Colleges with the object of post-graduate training, resulting in an intercollegiate foundation course in nutrition. Over 250 courses have been completed.

This had led to new approaches on how to think about nutritional management: 'it's broader than treating the individual condition.' Professor Jackson said that a new philosophy of care was necessary, in which individual conditions are not treated in isolation; that was evidence-based, and which had suitable interventions and placed the doctor as part of an integrated service delivery linking primary, secondary and tertiary care.

Professor Jackson went on to say that the conference signalled to him that 'we are ready to talk in a broader framework on how we can interact effectively within the system to improve nutritional care.' He referred to the NHS's October 2002 draft standards for Scotland indicating that nutritional issues in Scottish hospitals are taken seriously.

'We need a suitable infrastructure, and we need professionals. And we need an appropriate ethos of care,' said Professor Jackson to the delegates in summing up. 'You are best people fitted to allowing us to create an appropriate ethos of care.'

**Question and Answer**

*Q: You focused on doctors, but nutrition is a multi-disciplinary profession. What about education, ethos, etc, in non-medical people? And do you think that Trusts as well as colleges can be involved in training and education, instilling such an ethos into these individuals?*

A: There are developments in nursing and pharmacy that focus on nutritional requirements. The fact that I focus on doctors doesn't reduce the responsibility of those professionals to develop a competence. Doctors currently don't justify the privilege of being focuses of advice; they have been obstacles to the progress of nutritional care. Changing doctors' minds is a very important step. The fact that the GMC has stated that they must be competent, allows us to move into the next iteration.

*Q: A little knowledge can be a dangerous thing. I'm not sure that a small amount of nutrition in the curriculum will help things. How do you anticipate these clued-up doctors of the future working with dietitians?*

A: I was careful to state a competency to be safe. Part of that is (1) to know your limitations, and (2) to call for help when you need it. I hope the next generation of doctors would be clued-up enough to recognise when they need help. One

of the challenges is to make sure that boundaries between different healthcare professionals are carefully managed.

*Q: I did some research into the relationship between caterers and dietitians, and inappropriate language. Since we became clinicians, we've upped our language, and there's quite a barrier between dietitians' language and caterers'. It made the caterers feel like lesser beings. I'd like to put in a plea for plain English. We communicate with patients with plain English, and we don't always do that in professional communication.*

A: I agree entirely. There is an important need to make sure that communication is clear.

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**Royal Liverpool Childrens Hospital NHST**
Roger Cooke, Chief Nurse
Paul McDonald, Catering Manager

**High Peak & Dales Primary Care Trust**
Tim Broadley, Director of Primary & Community Care Services
Dianne Jeffrey, Chairman

**Barking, Havering & Redbridge Hospitals NHST**
Jackie Doyle, Associate Director, Facilities

**Barking, Havering & Redbridge Hospitals NHST**
Caroline Moore, Clinical Resource Manager
John Wood, Director of Clinical/non clinical support services
Charles Musker, Deputy Manager, Facilities

**The Pennine Acute Hospitals NHST**
John Wilkes, Director of Facilities
Denise Houghton, Director of Nursing

**Nottinghamshire Healthcare NHST**
Mrs J Collins, Non-Executive Director
Beverley McLeod, Hotel Services Manager

**Newham Healthcare NHST**
Catherine Snelling, General Manager - Non Clinical & Business Support
Warren de Souza, Facilities Manager

**Oxford Radcliffe Hospitals NHST**
Trevor Payne, Assistant Director of Operational Services - Facilities

**South Tyneside PCT**
Alan Kerr, Non-Executive Director

**Kingston PCT**
Julie Sherlock, Operational Services Manager
Fiona Hegarty, Manager - Older People's Services

**Barts and the London NHST**
Angela Robinson, Senior Nurse - Specialist Medicine
Steve Saunders, Director of Capital and Facilities
Maggie Rogers, Associate Chief Nurse

**East Somerset NHST**
Alison Lobb, Patient Services Manager
Dena Ponsford, Support Manager

**Middlesborough PCT**
Allison Welsh, Modernisation Manager

**East Kent Hospitals NHST**
John Mills, Deputy Director of Facilities
Frank McCarvill, Hotel Services Manager

**Erewash PCT**
John Floyd, Non-Executive Director

**Great Ormond Street Hospitals NHST**
Peter Wollaston, Assistant Director of Estates and Facilities
Lizzy Hand, Acting Head of Facilities

**Berkshire Shared Services (all Trusts in East & West Berkshire PCTs**
Daughne Taylor, Performance Manager
Paul Rowley, Assosiate Director of Facilities

**South East Oxon PCT**
Amanda Austin, Deputy Director of Clinical Services

**Maidstone Weald PCT**
Sue Brown, Modern Matron

**Portsmouth Healthcare NHST**
Toni Scammell, Senior Nurse
Rosie Paxton, Premises Manager

**Community Health Sheffield**
Ken Lawrie, Director of Supplies & Support Services
Phil Rookes, Hotel Services Advisor

**North Bristol NHST**
Karoline Rowlands, Facilities Manager - Hotel Services
Professor Phyllida Parsloe, Chair

**City Hospitals Sunderland**
George Hood, Divisional General Manager

**South West London and St George's Mental Health NHST**
Jo Cantelo, Deputy Head of Operational Services

**Wolverhampton PCT**
Lindsay Ibbs George, Catering Co-ordinator
Joanne Appleby, Modernisation Manager (facilities)

**Worcestershire Acute Hospitals NHST**
John Summers, PFI Project Director
Mrs V A Harris, Head of Facilities
Neil Watson-Jones, Trust Catering Manager

**Queen Elizabeth Hospital NHST**
David Blaxland, Modernisation Officer
Rebecca Morgan, Director of Modernisation

**West Middlesex University Hospital NHST**
Ray Plummer, Associate Director of Facilities
Bridget Fletcher, Deputy Director of Nursing

**South West London Strategic Health Authority**
Shirley Harris, Non-Executive Director
Debbie Stubberfield, Lead Nurse

**Bedfordshire Heartlands PCT**
Janet Goll, Senior Nurse Manager

**Oxleas NHST**
Lin White, Head of Facilities

**East Cheshire NHST**
Mike O' Boyle, Director of Nursing and Quality

**Devon Healthcare NHST**
Ann Edworthy , Senior Sister
Marcia Gibbs, Senior Sister

**Wandsworth PCT**
Peter Leighton, Assistant Facilities Manager

**Bedfordshire Shared Services NHST**
Fiona Benson, Contracts Manager
Margaret Thornley, Director of Nursing
Mr C Nattrass, Head of Estates and Facilities

**Hinchingbrooke Health Care NHST**
Jeanette Firrell, Non Executive Trust Board member
Peter Brooker, Support Services Manager

**North Staffordshire Combined Healthcare NHST**
Janet Greener, Deputy Head of Support Services
Maxine Prior, Modern Matron
Joe Boulton, Non-Executive Director

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**Castle Point & Rochford PCT**
Debbie Bamber, Non-Executive Director

**Kings College Hospital NHST**
Gerald Clemence, General Manager - Facilities

**Kings College Hospital NHST**
Pam Marley, Deputy Site Manager - Sodexho

**Papworth Hospital NHST**
Angela Fritz, Non Executive Director

**East Sussex County Healthcare NHST**
William McCartney, Catering Manager
Pam Oates, Non-Executive Director

**United Lincolnshire Hospitals NHST**
Liza Grenfell, Non-Executive Director

**Gloucestershire Partnership NHST**
Ian Gregory, Director of Service Development
Marieanne Bubb-Sacklyn, Modern Matron

**St Mary's NHST**
Susan Osbourne, Director of Nursing
Baroness Joan Hanham CBE, Chairman

**Central & North West London NHST**
Martin Whittle, Director of Strategic Development

**Tees & North East Yorkshire NHST**
Eileen Grace, Chair
Paul Newton, Director of Learning Disability Services

**The Cardiothoracic Centre-Liverpool NHST**
Kenneth Hoskisson, Chairman
Philip Heaps, Support Services Manager

**Torbay PCT**
Mike Wickens, Chair

**Oxfordshire Mental Healthcare NHST**
John Poole, Catering Manager
Duncan Smith, Director of Finance

**Rushcliffe PCT**
Lynne Sharp, Corporate Services Manager
Chrissie Craske, Senior Clinical Charge Nurse

**Daventry and South Northants PCT**
Andrew McLester, Risk, Estate and PFI Manager
Jaymie Middleton, Hotel Services Manager

**Stockport NHST**
Andy Proctor, Hotel Services Manager

**Mid Cheshire Hospitals NHST**
David Newton, Vice Chairman

**Tendring PCT**
David Re, Chairman

**Bournemouth University**
Dr John Edwards, Professor of Food Service

**Walsall Hospitals NHST**
Cliff Hubbold, Non Executive Director
Keith Palmer, Senior Support Services Manager (Hotel Services)

**West Wiltshire PCT**
Ann Merrils, Non Executive Director
Ian McLellan, Contracts & Quality Manager

**North Surrey PCT**
Wyn Pockett, Non-Executive Director

**Bedford Hospital NHST**
Steve Morgan, Operational Support Services Manager
Dr R Main, Non Executive Director

**Hillingdon PCT**
Stephanie Jones, Modern Matron

**North Birmingham Primary Care Trust**
Tina Doherty, Clinical Team Leader
Jean Brunn, Houskeeper

**Blackburn, Hyndburn & Ribble Valley Healthcare NHST**
Michael Hall, Director of Operations

**Maldon & South Chelmsford PCT**
Tony Plumridge, Chairman

**Lewisham Hospital NHST**
Bala Gnanapragasam, Chairman

**Isle of White Healthcare NHST**
Rodney Ireland, Chairman
Malcolm Bennet, Catering Services Manager

**S Worcs PCT**
Mrs Yvonne Milne MBE

**Havering Primary Care Trust**
Debra Collard, Non Executive Director
Lesley Buckland, Non Executive Director

**Havering Primary Care Trust**
John Tobin, Head of Older Peoples' Services

**NHS Purchasing & Supply Agency**
Helen Cotterill, Buyer
Bob Seeley, Senior Buyer
Alan Glover, Senior Buyer

**InterserveFM Ltd**
Sue Plews, Company Dietitian

**Buckinghamshire Mental Health NHST**
Phil Thomas, Business Support Manager for Support Services
Debra Rickatson, Administration Manager

**Maidstone & Tunbridge Wells NHST**
Jeanette Rooke, Hotel Services Manager
Paul Rhodes, Catering Manager

**Lincolnshire NHS Shared Services**
Mr M Scott, Director
Mrs S Teskey, Support Service Development Manager

**Heatherwood & Wexham Park Hospitals NHST**
Paul Grant, Nurse Executive Director
Sue Batty, Head of Patient Environment

**East and North Hertfordshire NHST**
Richard Harman, Director of Assets and Facilities
Jeremy Croxford, Head of Catering

**Sheffield Childrens NHST**
Brian Smith, Director of Healthcare Facilities
John Turner, Non Executive Director

**Redbridge PCT**
Naomi Jones, Senior Dietitian
Sangita Lall, Head of Facilities & Dietetics

**Bromley Hospitals NHST**
Angela Gibb, Dietetic Services Manager

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**East Birmingham PCT**
Brendan O' Brien, Non-Executive

**Royal Brompton & Harefield NHST**
Mike Dukket, Catering Manager
Sarah Illingworth, Chief Dietitian

**Swale PCT**
Gillian Sainsbury, Community Hospitals Manager

**Royal West Sussex NHST**
Chris Pile, Non Executive Director

**Norwich PCT**
Dr John Vinookumar, Non Executive

**South Tyneside Healthcare NHST**
Steve Foster, Executive Director of Facilities
Peter Brigham, Catering Manager

**County Durham & Darlington Priority Services NHST**
Jo Turnball, Chairman
Chris Parsons, Director of Facilities Management

**York Health Services**
Penny Lawrence, Hotel Services Manager

**West Kent Shared Service Agency**
Debbie Clarke, Deputy Director of Facilities

**East Kent Community NHST**
Derek Bates, Acting Director of Estates and Facilites

**South Birmingham PCT**
Julie Ravenhill, Assistant to the Services Director
Elaine Round, Catering Manager

**Leeds Teaching Hospitals NHST**
Pam Miller, General Manager - Contracts & Support Services
Trevor Reed, Non Executive Director
Diane Palmer, Acting Deputy Chief Nurse

**Frimley Park Hospital**
Janet King, Director of Personnel and Facilities

**Good Hope Hospitals NHST**
Jenny Brown, Non Executive Director

**Harrogate Health Care NHST**
Steve Warren, Director of Facilities

**Canterbury and Coastal PCT**
Tina Lund, Modern Matron

**North West London Strategic Health Authority**
Alexander Ashton, Non Executive Director
Jane Marr, Director of Nursing

**Royal Berkshire and Battle Hospitals NHST**
Meta Muncaster, Trust Facilities Manager
Keith Westwood, Acting Director of Facilites

**Kings Lynn and Wisbech Hopitals NHST**
Ann Purt, Non Executive Director
Colin Weston, Director of Operations and Deputy Chief Executive

**Chelsea and Westminster Hospitals NHST**
Therese Davis, Director of Nursing and Patient Services
John Elliott, Interim Director of Facilities
Annabel Bond, Project Manager

**United Bristol Healthcare NHS Trust**
Helen Brown, Chief Dietitian, Food Policy

**Dartford and Gravesham NHST**
Elaine Butler, Corporate Services Manager
Judith Webb, Head of Nutrition and Dietetics

**Shepway PCT**
Andrew Barchi, Chairman

**University of Westminster**
Dr Carrie Ruxton, Senior Lecturer on Nutrition

**Queen's Medical Centre, University Hospital NHST**
Ann Micklewright, Dietetic & Nutrition Services Manager

**South London & Maudsley NHST**
Zoe Reed, Director of Developing Organisation & Community
Pam Wastell, Estates & Facilities Business Manager

**Cambridgeshire & Peterborough Mental Health Partnership NHST**
Gill Wild, Non Executive Director

**Royston Buntingford & Bishops Stortford PCT**
Mavis Garner, Chairman

**King's College Hospital NHST**
Paula Sibley, Assistant Director of Nursing

**Leicestershire Partnership NHST**
Liz Tebbutt, Facilities Support Manager

**Taunton & Somerset Hospital NHST**
Jeanette Keech, Non Executive Director

**Milton Keynes PCT**
Chris Behrendt, Facilities Manager

**Royal Surrey County Hospitals NHST**
Jo Bell, Nurse Manager

**Sherwood Hospitals NHST**
Sheilah Andrews, Non-Executive Director
Carolyn White, Executive Nursing Director

**Royal Shrewsbury Hospital NHST**
Rose Manger, Non Executive Director

**Medway Maritime Hospitals NHST**
Jacqui Briers, Trust Catering Manager

**Surrey & Sussex Healthcare NHST**
Nigel Kee, Director of Nursing and Patient Services
Linda Taylor, General Manager - Facilities

**Portsmouth Hospitals NHST**
Steve Jones, Unit Catering Manager
Lynn Williams, Assistant Unit Catering Manager

**Royal National Hospital for Rheumatic Diseases**
Nigel Elwell, Catering Manager

**East Kent Hospitals NHST**
Mr Leslie Bulman, Non Executive Director

**Leicestershire and Rutland Healthcare NHST**
Nan Rooke, Clinical Nurse Leader

**Bolton PCT**
Lynne Price, Team Co-ordinator, District Nursing

**Surrey Hampshire Borders NHST**
Julia Hammond, Hotel Services Manager
David Longley, Hotel Services Co-ordinator / Trust Catering Advisor

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**Kingston Hospitals NHST**
Alan Pearse, Director of Corpotate Development & Deputy Chief Executive
Joan Scriven, Dietetics Services Manager
Diane Lee, Operational Services Manager

**St Georges Healthcare NHST**
Amy Gass, Matron for General and Vascular Surgery

**Royal United Hospital Hospital NHST**
Stephen Holt, Director of Facilities

**Burnley Healthcare NHST**
Julie Turner, Hotel Services/Site Manager
Jo Walmsley, Hotel Services Manager

**Staffordshire Moorlands PCT**
Monica Ball, Support Services Manager
Pauline Pepper, Support Services Manager

**Royal Wolverhampton NHST**
Mike Towler, Head of Hotel Services
Roy Waldon, Catering Manager

**Sussex Downs & Weald PCT**
Lesley Kennet, Support Services Manager

**Newham Healthcare NHST**
Janice Carter, Catering Manager
Nicole Simpkins, Project Team leader

**Hospital Bulletin Magazine**
David Stephenson, Editor

**Bolton, Salford & Trafford Mental Health Partnership NHST**
Paul Holt, Deputy Director of Facilities

**Compass Group**
Steven Hall, Development Manager
Ian Moore, Strategic Development Director

**Authentic Speciality Foods**
Phil Ellis, Director Foodservice Sales & Marketing

**The Princess Alexandra Hospitals NHST**
Dorothy Bioletti, Facilities Business & Quality Manager

**South Devon Healthcare NHST**
Cathy French, Non-Executive Director

**North Herts and Stevenage PCT**
Jane Say, Senior Lecturer

**Hertfordshire Partnership NHST**
Roger D'Elia, Operational Services Manager

**Barnet and Chase Farm Hospitals NHST**
Nadia Conway, Vice Chairman

**North Middlesex University Hospital NHST**
Frances Kipling, Facilities Manager

**West London Mental Health NHST**
William Martin, Head of Leadership Development

**North Staffordshire NHST**
Sandra Roberts, Catering Manager

**Burntwood, Lichfield and Tamworth PCT**
Liz Smart, Non-Executive

**North East Derbyshire PCT**
Trisha Owen, Director of Nurse Development
William Jacob, Director of Operations

**East Hampshire PCT**
Jacqueline Oliver, Non Executive Director

**Lancashire Teaching Hospitals**
Brian Booth, Chair

**Hammersmith Hospitals NHST**
Shirley Hanazawa, Monitoring Dietitian
Gary Frost, Head, Nutrition & Dietetics

**Atlas Media Group**
Fiona Broomfield, PR Executive

**Mendip PCT**
Wendy Marshfield, Assistant Director of Clinical Services

**Sodexho**
Michelle Philpott, Managing Director
Les Darlington, Sales Director
Anne Donelan, Dietetic Services Manager

**Basildon & Thurrock University Hospitals NHS Trust**
Helen Blowes, Head of Nursing Practice

**Dorset & Somerset Strategic Health Authority**
Marie Sanderson, Project Manager - Strategic Development

**Norfolk and Norwich University Hospital NHST**
Aubrey Coleman, HR Manager

**Gloucestershire Hospitals NHST**
Jane Evans, Support Services Manager

**Mabel Blades**
Freelance Dietitian

**Jackie Smith**
Freelance Dietitian

**West London Health Estates and Facilities Management**
Yuen Marusic, Facilities Manager

**Enfield PCT**
Yasemin Brett, Non Executive Director

**Birmingham Heartlands & Solihull NHST**
Dr Sue Balmer, Non Executive Director

**NHS Scotland Property & Environment Forum Executive**
Evelyn Russell, Business Manager

**Apetito Ltd**
Rosemary Hoyle, Divisional Manager Healthcare

**Essex Rivers Healthcare NHST**
Elizabeth Stalley, Head of Facilities
Sarah Williams, Senior Dietitian

**The Royal Surrey County Hospital NHST**
Janet Carr, Facilities Manager

**Kensington & Chelsea PCT**
Hilary Pillay, General Manager - Matron
Su Lazarus, Deputy Facilities Manager

**County Durham and Darlington Acute Hospitals NHST**
Alison McCree, Head of Hotel Services

**South West Oxfordshire NHST**
Maureen Warner, Head Nurse

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**Royal National Orthopaedic Hospital NHST**
Eric Fehily, Director of Facilities and Estates

**Dorset Healthcare NHST**
Chris Lay, Hotel Services Manager

**Royal Brompton Hospital NHST**
Caryn Straker, Senior Dietitian

**Patients Food Group**
Duncan Shepard
Doug Dale
Sylvia Whitrod

**Patients Food Group/BHF Panel**
Hilary Rowbottom

**Better Hospital Food Panel**
Iqbal Wahab
Jane Cooke, Frimley Park Hospital
Mario Wyn Jones

**PEAT**
Rod Gray

**Patients Association**
Simon Williams, Director of Policy

**Patients Association/Patient Food Group**
Roger Goss, Co-Director

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Liz Walters

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